STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,
Petitioner,

File No. 98-88265-CR

v

Hon. James R. Giddings

MICHIGAN HEALTH MAINTENANCE
ORGANIZATION PLANS, INC., a
Michigan health maintenance organization,
doing business as OmniCare Health Plan,
Respondent.
_____/

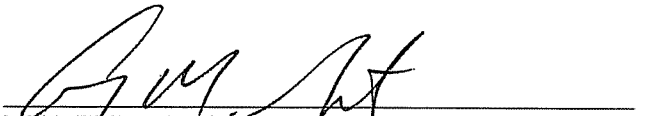
MARK J. ZAUSMER (P31721)
AMY M. SITNER (P46900)
Zausmer, Kaufman, August & Caldwell, P.C.
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, MI 48334
(248) 851-4111
_____/

NOTICE OF HEARING

PLEASE TAKE NOTICE THAT the Petition for Order Approving Settlement of The Detroit Medical Center's Proof of Claim Dated February 15, 2005, Alleging, Inter Alia, Breach of Contract and Misrepresentation will be held before this Honorable Court on October 5, 2006, at 3:00 p.m., or as soon thereafter as counsel may be heard.

Respectfully, Submitted,

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.



MARK J. ZAUSMER (P31721)
AMY M. SITNER (P46900)
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, MI 48334
(248) 851-4111

Dated: August 24, 2006

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,
Petitioner,

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Farmington Hills, MI 48334
(248) 851-4111
_____/

PETITION FOR AN ORDER APPROVING SETTLEMENT OF THE DETROIT MEDICAL CENTER'S PROOF OF CLAIM DATED FEBRUARY 15, 2005, ALLEGING, *INTER ALIA*, BREACH OF CONTRACT AND MISREPRESENTATION

Linda A. Watters, Director of the Michigan Office of Financial and Insurance Services, in her capacity as Liquidator of Michigan Health Maintenance Organization Plans, Inc., through her attorneys, Zausmer, Kaufman, August & Caldwell, P.C., petitions this Court for an Order approving a settlement reached by the Liquidator and the Detroit Medical Center ("DMC") regarding the value and classification to be assigned to the DMC's Proof of Claim dated February 15, 2005. Following a thorough review of the claim and negotiations between the parties, the Liquidator recommends that the Court approve this claim as a Class 2 claim in the amount of $750,000.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

I. Background

This matter arises from a Proof of Claim ("POC") filed by the DMC in the liquidation proceedings of Michigan Health Maintenance Organization Plans, Inc. ("Michigan HMO"), formerly known as OmniCare Health Plan, Inc. ("OmniCare"). OmniCare, while in rehabilitation, entered into a capitated contract with DMC under which DMC was paid a "per member per month" rate to provide medical services to certain OmniCare members. DMC's POC, attached hereto as Exhibit A, alleges that DMC incurred a substantial loss as a result of flawed compensation calculations in the contract, which DMC contends resulted from purported bad faith or misrepresentation by OmniCare in negotiating and administering this contract. The POC contains "counts" alleging breach of contract, misrepresentation and other theories of recovery, and seeks damages of more than $36.5 million.

In connection with the hearing to establish the priority of various claims filed in the liquidation proceedings, consistent with MCL 500.8142, the DMC argued that the subject POC sought only reimbursement for medical services provided by the DMC to OmniCare members and, therefore, that any amount awarded under the POC should, like other claims filed by medical providers, be categorized as a Class 2 claim. The Liquidator argued, however, that the nature of the claims stated in the POC – for breach of contract and misrepresentation, potentially involving claims of bad faith – were of a type that could more appropriately be classified as Class 5 (general creditor) claims. Following argument on this issue, the Court entered an Order dated November 8, 2005, holding in abeyance the issue of the classification to be assigned to any amount awarded under this POC. Exhibit B.

With respect to the substance of the claim, the Deputy Liquidators extensively investigated and evaluated the DMC's claim, following which the parties engaged in negotiation regarding the value of the claim.

II. The Settlement

Subject to the approval of this Court, the Liquidator and the DMC have agreed to a settlement under which the POC will be approved in the amount of $750,000 and assigned a Class 2 status.

III. Effect of Settlement on Other Claimants

The document attached as Exhibit C shows the impact of the proposed settlement on the various claims on file with the Estate. The comparison shows the currently anticipated distribution by class under three scenarios: (1) if the DMC claim were valued at $0, (2) if the DMC claim were valued as proposed in the settlement and (3) if the DMC claim were valued at the same amount ($750,000) but categorized as a Class 5 (general creditor) claim.

This chart demonstrates that the only anticipated impact will be to Class 6 creditors,[1] who are projected under the proposed settlement to be reimbursed at a level of 11 cents on the dollar, rather than the 39 cents on the dollar that they would likely receive if the DMC claim were to be denied entirely. All Claimants in Classes 2, 3 and 5 are projected to receive 100 cents on the

[1]Class 6 consists of "Claims of any state or local government." MCL 500.8142(f). Currently, the claims on file in this category are: (1) a Regulator Assessment Fee of $36,000 imposed by the Office of Financial and Insurance Services for services provided in connection with the Rehabilitation and Liquidation of OmniCare and (2) a claim of $2,563,000 for Quality Assurance Assessment Program ("QAAP") Tax liability filed by the Michigan Department of Community Health.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

dollar for their approved claims under any of the given scenarios. Therefore, these claims are not expected to be impacted at all by the settlement.[2] Similarly, Claimants in Classes 7 and 8 are currently projected to receive no payout on their claims under any scenario and therefore should not be affected by the proposed settlement.

If the Liquidator were to deny the DMC's POC entirely, this would almost certainly lead to complex and time-consuming litigation between the parties, which would (1) result in the Estate incurring significant administrative (Class 1) costs, including attorneys and experts fees, in defending the claim and (2) delay the closing of the Estate and related payment of claims. And, of course, while such litigation could result in a determination that the DMC was entitled to no payout on the POC, or a smaller payout than the amount of the settlement, it could also result in a substantially higher valuation of the DMC's claim, which could threaten the currently-anticipated 100% payout on Class 2, 3 and 5 claims.

IV. Michigan HMO's Best Interest

The Liquidator, in consultation with the Deputy Liquidators and counsel, has fully reviewed the background of this claim, including the scenarios set forth in Section III above, and is satisfied that the settlement described in this Petition is in the best interests of Michigan HMO.

V. Conclusion

Based on the foregoing the Liquidator requests that the Court enter an Order approving the DMC POC in the amount of $750,000 and categorizing that claim as a Class 2 claim.

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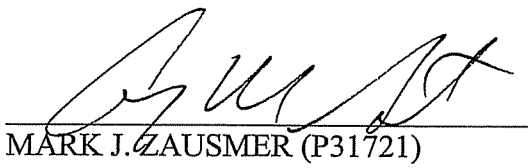
[2]The Estate has received no claims that fall under either Class 4 or Class 9.

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

Respectfully submitted,

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.



MARK J. ZAUSMER (P31721)
AMY M. SITNER (P46900)
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, Michigan 48334
(248) 851-4111

Dated: August 24, 2006

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
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STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,
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Hon. James R. Giddings

MICHIGAN HEALTH MAINTENANCE
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Farmington Hills, MI 48334
(248) 851-4111
_____/

PROOF OF MAILING

COUNTY OF OAKLAND)
) ss
STATE OF MICHIGAN)

FREDA A. RUCINSKI states that on August 24, 2006, she served a copy of the Petition for Order Approving Settlement of The Detroit Medical Center's Proof of Claim Dated February 5, 2005, Alleging, *Inter Ali,* Breach of Contract, and Misrepresentation, Notice of Hearing, and Proof of Mailing by enclosing copies of said documents in sealed envelopes, with prepaid, first-class postage affixed and addressed to:

Mr. Patrick J. Haddad
500 Woodward Avenue
Suite 2500
Detroit, Michigan 48226-3427

ZAUSMER, KAUFMAN, AUGUST & CALDWELL, P.C.,
31700 MIDDLEBELT ROAD, SUITE 150, FARMINGTON HILLS, MI 48334-2374 • 721 N. CAPITOL, SUITE 2, LANSING, MI 48906-5163

Mr. E. John Blanchard
Mr. David W. Silver
P.O. Box 30754
Lansing, Michigan 48909

Mr. Alan Rogalski
Foster, Swift, Collins & Smith, P.C.
32300 Northwestern
Suite 230
Farmington Hills, Michigan 48334

Mr. Ted K. Yasuda
233 North Michigan Avenue
7th Floor
Chicago, IL 60601

Mr. Michael R. Bell
525 West Ottawa Street
2nd Floor
P.O. Box 30754
Lansing, Michigan 48909

Mr. Charles N. Raimi
Harper University Hospital Legal Affairs
3990 John R
Detroit, Michigan 48201-2018

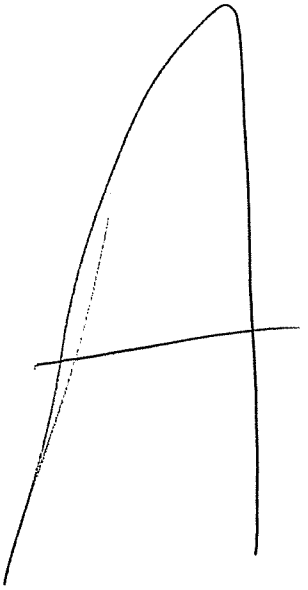
Mr. David J. Poirier
Young & Susser, PC
26200 American Drive, Suite 305
Southfield, Michigan 48034

Mr. William S. Hammond
Nuyen, Tomtishen & Aoun, P.C.
640 Griswold Street
Northville, Michigan 48167

Mr. Gerard Mantese
Mantese & Associates, P.C.
1361 East Big Beaver Road
Troy, Michigan 48083

and depositing said envelopes in the U.S. mail, in Farmington Hills, Michigan.

FREDA A. RUCINSKI



Michigan Health Maintenance Organization Plans, Inc. (in Liquidation)

Formerly OmniCare Health Plan in Rehabilitation

Ingham County Circuit Court File No. 98-88265-CR

For Office Use Only:
Date Proof Received:_____
Proof of Claim #:_____

"PROOF OF CLAIM"

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (in LIQUIDATION) (FORMERLY OMNICARE HEALTH PLAN IN REHABILITATION)

DEADLINE FOR FILING: MARCH 31, 2005

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM. EACH SECTION MUST BE FULLY COMPLETED. INSTRUCTIONS ARE ATTACHED. IF ADDITIONAL COPIES ARE NEEDED, PLEASE PHOTOCOPY OR DOWNLOAD FORM: WWW.OCHP.COM. FILE A SEPARATE "PROOF OF CLAIM" FOR EACH BATCH OF CLAIMS.

PERSON OR ENTITY MAKING CLAIM AGAINST MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC. (formally OmniCare Health Plan in Rehabilitation):

1. NAME: Detroit Medical Center
2. MAILING ADDRESS: Legal Affairs--3990 John R, 7 Brush West, Detroit, MI 48201
4. TELEPHONE NUMBER (DAYTIME): Charles Raimi (313) 887-5381
5. **CLAIM IS FROM: (Check "X" or specify below)**

   A. ( ) Member — Provide Social Security or OmniCare ID No:_____

   B. (X) Provider — Federal tax I.D. No. of Payee: 38-257-1767
   Social Security No. of Payee:_____ (if applicable)

   Providers Note: Each member claim must be submitted on UB 92 or CMS 1500 (HCFA 1500) claim forms. Also see "Instructions" (No. 1) about the "Proof of Claim" process for already adjudicated member claims.

   C. ( ) Trade Creditor for amounts owed on open account — Social Security or Federal Tax I.D. No:_____

   D. ( ) All other claims - please explain and provide Social Security or Federal Tax I.D. No. :_____

6. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required. See Attached

7. **NUMBER OF CLAIMS: AND TOTAL AMOUNT OF YOUR CLAIM(s):** $36,685,911.00 . If amount of claim is unknown, insert words "Unstated Amount." Provider claims amount would be based on 'charges'. You may amend your timely filed claim up until the final date of adjudication. Please attach all documents, contracts and invoices. If they are voluminous, please attach a summary.
8. No part of the debt has been paid, except N/A
9. There are no setoffs or counterclaims to the debt, except N/A
10. There is no security for the debt, except N/A

The undersigned claimant affirms that the representations and information contained in this "Proof of Claim" are true and correct to the best of your knowledge. You also understand that any statements or representations contained herein which knowingly present a false claim is a criminal offense punishable under Michigan Law.

Dated: Feb 15, 2005

This claim is in addition to DMC's claim for unpaid hospital/ medical charges, which will be filed separately.

Detroit Medical Center
By: Charles N. Raimi
Claimant's Name (please print or type)
Signature
Title (if applicable) Associate General Counsel

1155 Brewery Park Blvd., Suite 250
Detroit, Michigan 48207-2638

phone (313) 259-4000
fax (313) 393-7944

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

E.L. COX, COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,

Petitioner,

V

File No. 98-88265-CR

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC., a Michigan health maintenance organization, doing business as OmniCare Health Plan,

Hon. James R. Giddings

Respondent.

/

DETROIT MEDICAL CENTER'S CLAIM FOR BREACH OF CONTRACT, MISREPRESENTATION, OR, IN THE ALTERNATIVE, IMPAIRMENT OF CONTRACT

The Detroit Medical Center respectfully submits this claim in the amount of $36,685,911. This claim is in addition to the DMC's claims for outstanding and unpaid hospital/medical charges, which claims are being filed separately. The factual and legal basis for this claim is as follows.

FACTS[1]

The DMC is a 501(c)(3) charitable organization. The DMC operates several hospitals within the City of Detroit and provides care to some 80,000 indigent patients each year, including a high percentage of Medicaid patients. The contract that governed DMC's relationship with Omnicare is attached as Exhibit A to Dr. Malone's affidavit, Ex. 1. That contract effectively ended when Omnicare's membership was transferred to Coventry as of October 1, 2004.

[1] This factual recitation is supported by the affidavit of Dr. Thomas Malone, Ex. 1.

The former DMC-Omni contract provides for Omnicare to pay DMC a monthly "capitation fee" for each Omnicare member assigned to the DMC. In exchange for that payment, DMC agreed to provide a variety of medical services for those Omnicare members. The total monthly payment to DMC was to be computed based on the per-member capitation fee, multiplied by the total membership assigned to DMC for the month in question. The per member capitation fee was initially computed based on medical utilization data provided by Omnicare which purported to show that the capitation fee would produce a total payment to DMC roughly equivalent to Medicaid fee-for-service rates.

Consistent with the parties' discussions, the Agreement provides that the DMC's compensation is to approximate Medicaid fee-for-service rates, as such rates might change over the term of the Agreement:

> "**Capitation Payment.** As compensation for Covered Services for Medicaid and Commercial Members described below, Plan shall make monthly Capitation payments to the DMC based on the number of Members assigned to the Participating Centers who are eligible to receive Covered Services. Initially, the monthly Capitation rate shall be sixty ($60.00) dollars per member per month. Effective April 1, 2002, the monthly capitation rate for Commercial Members shall be fifty-seven ($57.00) dollars per Member per Month, and the monthly Capitation for (a) Aid to Families with Dependent Children ("AFDC") Members shall be forty ($40.50) dollars and fifty cents per AFDC Member per month, and (b) Assistance to the Blind or Disabled ("ABAD") Members shall be two hundred ($200.00) dollars per ABAD Member per month. The DMC shall accept such Capitation as payment in full for Covered Services rendered during that month to Members assigned to the Participating Centers less the Withhold stated below. The above Medicaid Capitation rates were derived applying projected utilization to the Medicaid DRG and per diem rates as set by the State of Michigan. Any changes in Medicaid DRG and per diem rates will be reflected as an adjustment to the Medicaid Capitation rates, effective concurrently with the date such changes are made by the State of Michigan." Ex. A, p. 29, section 1, emphasis added.

DMC later learned that the utilization data provided by Omnicare and used to compute the initial per member capitation fee was extremely inaccurate and misleading.

The population of Omnicare enrollees that was assigned to DMC was far sicker than suggested by the utilization data provided by Omnicare. The population assigned to DMC included many individuals suffering from long term chronic illnesses including diabetes, hepatitis, HIV/AIDS, etc., requiring DMC's expenditure of enormous resources in their care and treatment.

On May 16, 2003, the DMC notified Omnicare that the capitation fee produced compensation to DMC that was far below Medicaid fee-for-service rates. Omnicare conceded that DMC's calculations were essentially correct, but nevertheless rejected DMC's request for an increase to bring the capitation rates in line with Medicaid fee-for-service rates. See correspondence attached to Dr. Malone's affidavit (Ex. 1) as Ex. B.

The Omni – DMC contract gave DMC the right to terminate the agreement at any time, without cause, on 150 days notice. Contract, Art. 11, p. 18. However, it was DMC's understanding that the Court overseeing the Omnicare rehabilitation proceeding had entered an order prohibiting providers, including DMC, from exercising its right to terminate the contract.

As a result of Omnicare's refusal to adjust the capitation fee, DMC continued to provide care to Omnicare enrollees at grossly inadequate rates, and continued to sustain tens of millions of dollars of losses. DMC has calculated the losses on the DMC – Omni contract as follows:

Year	Loss compared with Medicaid fee-for-service rate
2002	$13,466,436
2003	12,472,748
2004	10,746,727
Total loss compared with Medicaid f/f/s rates (See exhibit C to Dr. Malone's affidavit for detail)	$36,685,911

DISCUSSION

I. BREACH OF CONTRACT

As shown above in the factual recitation, the contract capitation rate was specifically intended to approximate Medicaid fee-for-service rates, and was to be adjusted accordingly. However, the capitation rate did not approximate Medicaid fee-for-service rates. That inadequate compensation represented a clear breach of the contract, and DMC is entitled to recover the sum of $36,685,911.

II. MISREPRESENTATION

The initial contract capitation rate was based on medical utilization data provided by Omnicare, and which Omnicare represented would be consistent with utilization under the contract. However, that utilization data was grossly inaccurate and misleading and resulted in a capitation rate which produced compensation to DMC far below Medicaid fee-for-service rates.

As a direct result of Omnicare's misrepresentations, DMC has sustained damages of $36,685,911.

III. MEDICAID LAW

Under applicable law and regulations, the Medicaid fee-for-service rate is intended to give providers such as DMC a minimally adequate payment so as to allow such providers to pay their costs of operations—including doctors, nurses, other medical staff, administrative staff, facilities' expense, etc., etc. Even in the absence of a contract, providers are entitled to recover Medicaid fee-for-service rates for services provided to Medicaid patients.

In this case, the Omni-DMC contract, contrary to the purpose and intent of Medicaid law, paid DMC an amount dramatically less than Medicaid fee-for-service

rates. That rate resulted from misrepresentation and/or a contract breach, and also was contrary to Medicaid law and regulations. For all of those reasons, this claim should be allowed in full.

IV. IMPAIRMENT OF CONTRACT.

DMC submits that it is entitled to recover its losses under the legal theories discussed above. However, in the alternative, DMC asserts a claim for impairment of contract. (DMC exercises its right under law to assert alternative theories of recovery. MCR 2.111(A)(2)).

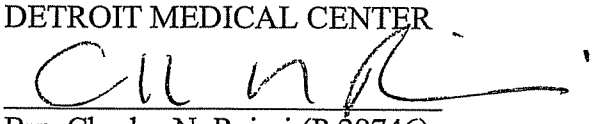
DMC had the contract right to terminate the Omni Agreement without cause. DMC was prohibited from exercising that right by the Court's injunction. DMC is entitled to recover its damages resulting from that impairment of contract. Michigan Constitution, Art. I, § 10.

CONCLUSION AND RELIEF

Regardless of the legal theory asserted, the bottom line is this: Omnicare's desperately ill enrollees needed medical care, they received that care at the DMC, and the DMC is entitled to at least recover compensation approximating Medicaid fee-for-service rates for providing that treatment. DMC has already sustained serious financial hardship as a result of Omnicare's rehabilitation, including the write off of tens of millions of dollars under the rehabilitation plan. Similarly, DMC now stands to receive only pennies on the dollar for its present claims.

For the reasons stated, DMC asks that the Court allow this claim in the amount stated, namely, $36,685,911, and that the Court allow the other claims submitted by the DMC in connection with this matter.

DETROIT MEDICAL CENTER



By: Charles N. Raimi (P 29746)
Deputy General Counsel
Floyd Allen (P 31260)
General Counsel
Detroit Medical Center Legal Affairs
3990 John R, Suite 7 Brush West
Detroit, MI 48201
Phone 313 887 5381
Fax 313 887 5110
Email crami@dmc.org

January ____, 2005

STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

THE DETROIT MEDICAL CENTER,

Plaintiff,

File No. 98-88265 CR

v

MICHIGAN HEALTH MAINTENANCE ORGANIZATION PLANS, INC., a Michigan health maintenance organization, doing business as OmniCare Health Plan,

Hon. James R. Giddings

Respondent.

_____/

AFFIDAVIT OF DR. THOMAS MALONE

Dr. Thomas Malone, being duly sworn, deposes and states as follows:

1. I am Executive Vice President of Medical and Academic Affairs for the Detroit Medical Center ("DMC"). This affidavit is made on my personal knowledge, or upon my review of documents maintained by the DMC in the ordinary course of business, or upon compilations of data prepared by DMC staff using documents maintained in the ordinary course of business.
2. The DMC is a 501(c)(3) charitable organization. The DMC operates several hospitals within the City of Detroit and provides care to some 80,000 indigent patients each year, including a high percentage of Medicaid patients.
3. The contract that governed DMC's relationship with Omnicare is attached as Exhibit A. That contract effectively ended when Omnicare's membership was transferred to Coventry as of October 1, 2004.

Ex. 1

4. I was directly involved with the negotiation of the DMC-Omnicare contract. The contract provides for Omnicare to pay DMC a monthly "capitation fee" for each Omnicare member assigned to the DMC. In exchange for that payment, DMC agreed to provide a variety of medical services for those Omnicare members. The total monthly payment to DMC was to be computed based on the per-member capitation fee, multiplied by the total membership assigned to DMC for the month in question. The per member capitation fee was initially computed based on medical utilization data provided by Omnicare which purported to show that the capitation fee would produce a total payment to DMC roughly equivalent to Medicaid fee-for-service rates.

5. Consistent with the parties' discussions, the Agreement provides that the DMC's compensation is to approximate Medicaid fee-for-service rates, as such rates might change over the term of the Agreement:

> "**Capitation Payment.** As compensation for Covered Services for Medicaid and Commercial Members described below, Plan shall make monthly Capitation payments to the DMC based on the number of Members assigned to the Participating Centers who are eligible to receive Covered Services. Initially, the monthly Capitation rate shall be sixty ($60.00) dollars per member per month. Effective April 1, 2002, the monthly capitation rate for Commercial Members shall be fifty-seven ($57.00) dollars per Member per Month, and the monthly Capitation for (a) Aid to Families with Dependent Children ("AFDC") Members shall be forty ($40.50) dollars and fifty cents per AFDC Member per month, and (b) Assistance to the Blind or Disabled ("ABAD") Members shall be two hundred ($200.00) dollars per ABAD Member per month. The DMC shall accept such Capitation as payment in full for Covered Services rendered during that month to Members assigned to the Participating Centers less the Withhold stated below. The above Medicaid Capitation rates were derived applying projected utilization to the Medicaid DRG and per diem rates as set by the State of Michigan. Any changes in Medicaid DRG and per diem rates will be reflected as an adjustment to the Medicaid Capitation rates, effective concurrently with the date such changes are made by the State of Michigan." Ex. A, p. 29, section 1, emphasis added.

6. DMC later learned that the utilization data provided by Omnicare and used to compute the initial per member capitation fee was extremely inaccurate and misleading. The population of Omnicare enrollees that was assigned to DMC was far sicker than suggested by the utilization data provided by Omnicare. The population assigned to DMC included many individuals suffering from long term chronic illnesses including diabetes, hepatitis, HIV/AIDS, etc., requiring DMC's expenditure of enormous resources in their care and treatment.

7. On May 16, 2003, the DMC notified Omnicare that the capitation fee produced compensation to DMC that was far below Medicaid fee-for-service rates. Omnicare conceded that DMC's calculations were essentially correct, but nevertheless rejected DMC's request for an increase to bring the capitation rates in line with Medicaid fee-for-service rates. See correspondence attached as Ex. B.

8. The Omni – DMC contract gave DMC the right to terminate the agreement at any time, without cause, on 150 days notice. Ex. A, Art. 11, p. 18. However, it was DMC's understanding that the Court overseeing the Omnicare rehabilitation proceeding had entered an order prohibiting providers, including DMC, from exercising its right to terminate the contract.

9. As a result of Omnicare's refusal to adjust the capitation fee, DMC continued to provide care to Omnicare enrollees at grossly inadequate rates, and continued to sustain tens of millions of dollars of losses. DMC has calculated the losses on the DMC – Omni contract as follows:

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Total loss compared with Medicaid f/f/s rates (See exhibit C for detail)	$36,685,911

Dr. Thomas Malone

Subscribed and sworn to before me this 13 day of January, 2005.

Notary Public

Oakland County, Michigan Acting in Wayne

My commission expires on 7/20/08

NANCY R. BROWN
NOTARY PUBLIC OAKLAND CO., MI
MY COMMISSION EXPIRES Jul 20, 2008

OMNICARE HEALTH PLAN
FACILITY PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made this 10th day of September, 2002, and is effective August 1, 2001, by and between The DETROIT MEDICAL CENTER, a Michigan nonprofit corporation (hereafter called the "DMC"), and OMNICARE HEALTH PLAN, a Michigan nonprofit corporation (hereafter referred to as "Plan").

WHEREAS, Plan is licensed as a health maintenance organization in the State of Michigan and has contracts with the State of Michigan, employers and other groups to arrange for the provision of health care services to enrolled members eligible for benefits in Plan's health benefit plans ("Products");

WHEREAS, DMC owns and operates several licensed hospitals and other facilities that deliver health care services to patients in accordance with the terms and conditions of various payor programs, including Plan;

WHEREAS, the parties hereto previously entered into a Letter of Agreement dated October 12, 2001 whereby the DMC agreed to provide Covered Services to Plan Members; and

WHEREAS, the parties now desire to enter into this Agreement to supersede the Letter of Agreement dated October 12, 2001 for the delivery of Covered Services to enrolled Members in the Plan.

NOW, THEREFORE, in consideration of the mutual covenants and promises contained herein, the parties, intending to be legally bound, agree as follows:

ARTICLE 1
DEFINITIONS

1.1 **Benefit Description Booklet** means the document which may be presented to a Member upon enrollment in Plan setting forth the health care services covered under the terms of the Products.

1.2 **Capitation** means the per Member per month payment made to the DMC by Plan for Covered Services provided to Members assigned to the Participating Centers hereunder.

1.3 **Certificate of Coverage** means the summary of terms and conditions for health care services that Plan arranges to be provided to Members enrolled in Products pursuant to the contract with the State of Michigan-Medicaid and various commercial groups. The Certificate of Coverage may vary among Members.

1.4 **Clean Claim** means a claim or encounter statement for Covered Services with detailed and descriptive medical and Member information that requires no further information or documentation in order to be processed or paid and does not involve nor is subject to an appeal

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or grievance procedure or third party liability, including Coordination of Benefits or subrogation. For Members in the Medicaid Product, Clean Claim shall have the meaning as set forth in MCLA 400.111i.

1.5 **Coinsurance** means the financial responsibility for Covered Services usually stated according to a fixed percentage, that a Member has as stated in the applicable Subscriber Agreement.

1.6 **Consulting or Specialist Physician** means any Physician to whom a Member is referred by a Primary Care Physician for special consultation and treatment.

1.7 **Coordination of Benefits** means those provisions by which Participating Providers, either together or separately, seek to recover costs of Covered Services provided to Members which may be covered by another insurer, service plan, government, third party payor or other organization subject to any limitations imposed by the Subscriber Agreement.

1.8 **Copayment** means a cost-sharing arrangement under the Subscriber Agreement in which a specified amount(s) must be paid by a Member to a Participating Provider at the time a specific Covered Service is rendered.

1.9 **Covered Service(s)** means the Medically Necessary hospital services set forth in Schedule 1.9 (Covered Services) to which a Member is entitled under the Subscriber Agreement.

1.10 **DMC Participating Hospital** means the individual hospital(s) that are owned and operated by the DMC identified in Schedule 1.10 (DMC Participating Hospitals) on which behalf the DMC enters into this Agreement.

1.11 **DMC Participating Health Professionals** means hospital based Health Professionals including Certified Registered Nurse Anesthetists (CRNA)'s, at DMC Participating Hospitals.

1.12 **Emergency Services** means Covered Services provided in connection with an emergent medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of her unborn child; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.13 **Health Professional** means a psychologist, social worker, podiatrist, dentist, nurse anesthetist or nurse, optometrist, or other individual licensed or certified to practice a health care profession other than medicine or osteopathy by the state in which he or she is located.

1.14 **Hospital** means any general or acute care facility licensed under applicable state law and accredited by an appropriate accrediting agency, e.g., JCAHO or AOA, that is primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of injured persons.

1.15 **Plan Provider Manual** means the policies and procedures of Plan, as revised from time to time, applicable to a Participating Provider.

1.16 **Medically Necessary** means those Covered Services which are required to identify, treat or avoid an illness or injury to a Member, as determined by Plan's Medical Director and which are: (a) consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury; (b) in accordance with generally accepted standards of medical practice; (c) not primarily for the convenience of the Member, the Member's attending or treating physician, or another health care provider; (d) the most appropriate frequency, location supply or level of service which can be safely provided to a Member, and (e) consistent with Plan's utilization and quality management guidelines regarding type and duration of treatment. When specifically applied to an inpatient Member, Medically Necessary shall also mean that the Member requires acute care due to the nature of the Member's condition, and that Member cannot receive safe and adequate care as an outpatient or in a less intensive medical setting.

1.17 **Member** means any person, including a Subscriber and the Subscriber's dependents, if applicable, eligible to receive health care services under the terms of a health care plan maintained by an employer, trust, insurer, the government, an individual or other payor for which Plan has agreed to arrange for the provision of certain health care services and for whom a premium has been paid.

1.18 **Non-participating Physician/Health Professional/Hospital** means any Physician, Health Professional or Hospital not associated with, employed by, or under contract with the DMC or Plan for the Products.

1.19 **Noncovered Services** means those health care services which are not Covered Services as defined in this Agreement in Schedule 1.9 and in the Subscriber Agreement and the Plan policy manuals.

1.20 **Plan** means OmniCare Health Plan, a Michigan nonprofit corporation organized and licensed as a health maintenance organization under the provisions of Act 252 of the Public Acts of 2000, as amended.

1.21 **Participating Center** means those Participating Providers described in Schedule 1.20 (Participating Centers) contracted with Plan to serve Members that are affiliated with the DMC for the purposes of Capitation as set forth in this Agreement.

1.22 **Participating Health Professional** means a Health Professional that has a contract with Plan, either directly or indirectly, to provide Covered Services to Members.

1.23 **Participating Hospital** means a Hospital that has a contract with Plan to provide Covered Services to Members.

1.24 Participating Physician means a Primary Care or Specialist Physician who has contracted with Plan to provide Covered Services to Members.

1.25 Participating Provider(s) means each and every Participating Physician, Participating Hospital and Participating Health Professional engaged in the delivery of health care services.

1.26 Physician means any doctor licensed to practice medicine or osteopathy in the state in which he or she is located.

1.27 Premium means the sum of money paid periodically to Plan by or on behalf of Members with health care coverage issued by Plan without regard to the number of Covered Services actually rendered.

1.28 Primary Care Physician means a Participating Physician duly licensed under state law whose practice is general practice, family practice, internal medicine, pediatrics or obstetrics and gynecology, who is primarily responsible for the health care of a Member and for coordinating all aspects of the Member's health care. Primary Care Physician shall hold Hospital admitting privileges at a Participating Hospital unless waived in writing in advance by Plan.

1.29 Purchaser means an entity that has contracted with Plan to arrange for the delivery and financing of health care services to individuals.

1.30 Quality Assurance Program means an ongoing program of Plan to monitor the quality of health care services delivered to Members. The program identifies quality issues and recommends corrective actions to be taken by Participating Providers.

1.31 Service Area means the geographic service area in which the Plan is licensed by the State of Michigan to operate a health maintenance organization.

1.32 Specialty Physician means a Participating Physician duly licensed under state law who has contracted with Plan, either directly or indirectly, to provide specialist care to Members in accordance with Plan's policies and procedures for Members.

1.33 Subscriber means any person who executes a written Subscriber Agreement or the person on whose behalf a Purchaser has paid for Covered Services and who is entitled to receive Covered Services specified in the Subscriber Agreement.

1.34 Subscriber Agreement means a written agreement between the Plan and a Subscriber, an employer, or other payor under which the Subscriber and the Subscriber's eligible dependents receive Covered Services.

1.35 Utilization Management means those procedures performed by Plan or its subcontractors to determine whether Covered Services, which have been or are to be provided to Members, are Medically Necessary, timely, and appropriate pursuant to the terms of this Agreement.

ARTICLE 2
RESPONSIBILITIES OF HOSPITAL PROVIDER

2.1 The DMC Representations and Warranties. DMC represents and warrants as follows:

2.1.1 That it is authorized to enter into this Agreement on behalf of each DMC Participating Hospital and their employees to contractually bind each DMC Participating Hospital to the terms and conditions of this Agreement and the Plan Provider Manuals. DMC warrants that all DMC Participating Hospitals and their employees are capable of delivering quality Covered Services to Members hereunder. DMC shall assure that each DMC Participating Hospital and its employees comply with each and every term and condition contained in this Agreement and the policies and manuals of Plan to deliver Covered Services to Members. References to the DMC in this Agreement shall include each DMC Participating Hospital and DMC Health Professionals.

2.1.2 That those Physicians and Health Care Professionals providing Covered Services hereunder are parties to valid service agreements with Plan containing such terms and conditions as required by this Agreement and that the DMC, when referring Members for consultation, hospitalization and ancillary health care services, shall only utilize Participating Providers approved by Plan in writing, unless otherwise expressly stated herein; and

2.1.3 That at all times during the term of this Agreement, each DMC Participating Hospital and DMC Participating Health Professional is, and shall remain, (a) licensed in the State of Michigan to provide continuous inpatient and outpatient care; (b) in good standing as a participant in third party payor programs with the Michigan Department of Community Health, Center for Medicare and Medicaid Services, and all other governmental/regulatory agencies related to the services to be provided hereunder; and (c) fully accredited by applicable accrediting agencies, including JCAHO or AOA. The DMC shall immediately notify Plan if there is a change, limitation, revocation, suspension or any proceeding affecting any of the foregoing qualifications. The DMC further agrees to notify Plan immediately in the event its relationship with a DMC Participating Hospital changes or is terminated.

2.1.4 That the DMC and all of its DMC Participating Hospitals and DMC Participating Health Professionals have never been convicted of a criminal offense related to health care nor have they been listed by a federal or state agency as debarred, excluded or otherwise ineligible for participation in any federal or state health payor program and, provided further, that the DMC will not provide Covered Services utilizing any professional or subcontractor excluded from participation in federal programs.

2.2 Administrative Services.

2.2.1 Delegated Activities. If Plan will be delegating credentialing and/or utilization management and quality assurance activities to the DMC, those activities shall be described on

the attached Schedule 2.2.1 (Delegated Activities) which is incorporated herein by reference. Any prior approvals to be obtained will be noted in Schedule 2.2.1 (Delegated Activities). Plan shall retain oversight and accountability for the results of these activities.

2.2.2 Data Collection. The DMC shall assist Plan in the collection and compilation of data and information for activities related to the Covered Services rendered hereunder including, but not limited to, credentialing, utilization management, and quality management. DMC shall provide to Plan such documentation requested by Plan for utilization of services and payment of Clean Claims in the format and timetable acceptable to Plan.

2.2.3 **Reports.** Plan shall provide monthly reports to the DMC regarding Members assigned to the DMC.

2.2.4 Cooperation. The DMC shall assist Plan in distributing policies and procedures for the Plan's Products to DMC Participating Hospitals and DMC Participating Health Professionals.

2.2.4 Subcontracting. The DMC shall include terms and conditions substantively similar to or identical to those contained in this Agreement in any subcontract or other arrangement the DMC undertakes with any provider of Covered Services pursuant hereto. Upon request, DMC shall supply the Plan, the State of Michigan, the federal government or their employees or agents with copies of all subcontracts which it enters into with subcontractors to perform DMC's duties and obligations pursuant to this Agreement. No subcontractor shall be deemed a Participating Provider under this Agreement without Plan's prior written approval.

2.3 Provision of Covered Services. DMC shall provide those Covered Services set forth in the Certificate of Coverage or as described in Schedule 1.9 (Covered Services) to Members on a 24 x 7 basis which are within the scope of the its licenses and certifications to provide health care services consistent with professional standards of medical care accepted in the community and in accordance with this Agreement and the Plan Provider Manual. Members shall be admitted to a DMC Participating Hospital by Participating Physicians who have medical staff membership and privileges in good standing at a DMC Participating Hospital, in accordance with the DMC's standard admitting policies, procedures and medical staff bylaws, rules and regulations, and in accordance with Plan's prior authorization procedures, where applicable.

2.3.1 Authorization and Precertification. Plan's requirements for referrals and precertification shall be met by the DMC for all Covered Services except in the case of Emergency Services. The DMC shall follow the procedures outlined in the Plan Provider Manual and in Schedule 2.3.1 (Procedures For Authorization) which govern the authorization and precertification of Members for the delivery of Covered Services hereunder.

2.4 DMC Participating Hospital Standards. Each DMC Participating Hospital shall provide Covered Hospital Services to Members enrolled in the Products that shall conform to (a) all federal, state and local laws, rules and regulations applicable to the provision of Covered Services; (b) applicable professional codes of ethics; (c) accepted and prevailing standards of

medical practice in the local community; (d) all applicable standards of accrediting agencies, including without limitation, JCAHO, AOA, and National Committee of Quality Assurance; (e) all of the terms and conditions of this Agreement and the Plan Provider Manual; and (f) applicable Medicare/Medicaid conditions of participation as set forth in federal and state statutes, regulations and manuals.

2.5 DMC Participating Health Professionals. This Agreement shall automatically bind each DMC Participating Health Professional. DMC shall require that each DMC Participating Health Professional by the terms and conditions of this Agreement and the Plan Provider Manual.

2.6 Credentialing. The DMC represents that it has established and is maintaining medical staff credentialing, recredentialing and quality assurance programs pursuant to, and in conformity with, state and federal laws and accreditation standards. The DMC shall cooperate with Plan in the Plan credentialing process and shall release information as requested by Plan. The DMC shall provide Plan with notices of adverse action taken against any Participating Physician credentialed by the DMC. The decision of Plan with respect to any Participating Provider's application for network participation with Plan shall be final and binding. The DMC shall immediately notify Plan of the termination or suspension of admitting privileges of any physician known to the DMC to be a Participating Physician.

2.7 Discharge Summaries. The DMC shall supply discharge summaries and/or any other medically related documentation, including the complete medical record (at $.05 per copy, for Covered Services rendered to Members upon request by Plan and/or its Participating Physicians. The DMC shall supply discharge summaries and other reports to the Member's Participating Physician or Plan within thirty (30) days of the request or earlier, if necessary.

2.8 Quality Programs. The DMC attests that it currently has in effect, and will maintain throughout the term of this Agreement, Hospital-based quality assurance, risk management and utilization review programs. The DMC shall participate in and cooperate with the decisions, rules and regulations promulgated by Plan in its Quality Assurance Plan, Utilization Management Program and any related quality improvement programs. Such participation and cooperation shall include participating in on-site medical records review, case management, pre-authorization and precertification processes, concurrent and retrospective review activities, referral processes and discharge planning activities with Plan personnel, state and federal regulators and representatives of credentialing or accrediting agencies.

2.8.1 Review Activities. The parties acknowledge that it is necessary for them to exchange information and cooperate fully regarding policies affecting the Products and the administration of this Agreement. The DMC shall monitor, evaluate and regulate the provision of Covered Services to Members by the DMC. The obligations under this Section include, but are not limited to, peer review activities and quality management activities in order to enable Covered Services to be provided to, and authorized for, Members in an economical and efficient manner consistent with standards stated more specifically in this Agreement. These activities shall be conducted by the DMC with oversight by Plan or at Plan's discretion, in order to permit

Plan to comply with all applicable regulatory and accreditation requirements. The DMC shall provide reports to Plan of its review activities on a periodic basis as specified by Plan and in accordance with the standards of National Committee for Quality Insurance ("NCQA").

2.9 Emergency Services. DMC shall assure Emergency Services are available 24 hours a day, seven days a week for Members. The DMC shall coordinate the provision of Emergency transportation as applicable hereunder. Admissions to the DMC for Emergency Services shall be reported to Plan within twenty-four (24) hours of the admission.

2.10 Provider/Patient Relationship. DMC shall maintain an independent professional/patient relationship with each Member who is a patient and shall exercise independent professional medical judgment in all aspects of medical care and treatment to said Members, including the quality and levels of such care and treatment. DMC shall be solely responsible to such Members for all treatment rendered. The DMC shall transfer Members assigned to the Participating Centers to the DMC Participating Hospitals when medically appropriate.

2.11 Facilities and Equipment. The DMC shall provide all professional, non-professional, and technical personnel, facilities, equipment and support services as may be reasonably necessary in the performance of services hereunder and for the delivery of Covered Services to Members pursuant to the Products. All personnel, facilities, equipment and support services must meet all appropriate state licensure and certification requirements, as required by applicable state and federal laws.

2.12 The DMC's Duty Upon Plan's Denial of Coverage. The DMC acknowledges and understands that Plan, where applicable, has the right to deny payment to the DMC for Covered Services which Plan determines are not provided in accordance with this Agreement, the Plan Provider Manual or Plan's policies and procedures. It is agreed that such a denial does not absolve the DMC of its professional responsibility to provide appropriate medical care to Members. Additionally, the DMC agrees that it shall not misrepresent to Members whether services are Covered Services or whether services are reimbursable to DMC by Plan. Such misrepresentations constitute grounds for immediate termination of this Agreement. The DMC shall have open clinical dialogue and communication with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

2.13 State Authority. The parties understand that this Agreement is subject to approval by the State of Michigan. If the State requires any changes to this Agreement, Plan and the DMC shall expeditiously cooperate with each other and the State to effect those changes or Plan may immediately terminate this Agreement.

2.14 Coverage and Continuity of Care. The DMC agrees to provide or arrange for twenty-four (24) hours per day, seven (7) days per week, to all Members assigned to the DMC subject to Plan's policies. The DMC shall ensure that all personnel who render Covered Services to Members hereunder work with Plan and other Participating Providers to ensure continuity of care of all Members.

2.15 Advance Directives. The DMC shall comply with state and federal law and Plan's policy to enable Members to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the Member's option, advance directives.

2.16 Compliance with Programs and Policies. In the performance of Covered Services pursuant to this Agreement, the DMC shall comply with all rules, policies and procedures of Plan which may be applicable to the DMC.

2.17 Noncovered Services. In the event a Member requests medical services which are not Covered Services, such services may be provided by the DMC at the Member's full cost and expense, provided that the DMC shall not charge amounts in excess of the DMC's normal and customary charge for such services, and provided further, the DMC has obtained the Member's written consent of his or her personal financial obligation in advance for the Noncovered Service.

2.18 Grievance Procedure. The DMC acknowledges that Members will pursue complaints, service concerns and grievances through Plan's Grievance Procedure. The DMC and Participating Providers agree to timely cooperate with Plan, the State of Michigan and any individual or organization designated by the State of Michigan in connection with the investigation and resolution of such complaints, service concerns and grievances. Further, the DMC may advocate on behalf of Members in any Grievance Procedure.

2.19 Audits. The DMC agrees to submit to medical, facility and/or financial audits conducted by appropriate federal and state agencies as well as Plan. The DMC agrees to allow appropriate representatives of Plan, OFIS, the Michigan Department of Community Health, and/or other state or federal agencies which administer the Products or have oversight responsibilities, access on request to the DMC for the purpose of inspecting the premises, books, records and any documentation of services to Members and to assure financial solvency and health care delivery capabilities. Additionally, the DMC agrees to submit to medical audits which may be performed by either Plan or by state and/or federal authorities as appropriate, relating to quality of care, utilization of services, and medical records. Plan will make a good faith effort in attempting to notify the party to be audited in advance of such an audit to the extent reasonably possible. This Section 2.19 shall survive termination of this Agreement.

2.20 Compliance with State/Federal Law. The DMC and Plan agree to comply with all current and applicable state and federal laws and regulations in their respective performance of duties and obligations under this Agreement, including, but not limited to, the Ethics in Patient Referrals Act ("Stark Law") and the Health Insurance Portability and Accountability Act.

2.21 Acceptance of Members. DMC hereby agrees to (a) accept and treat Members without discrimination based upon age, gender, race, color, religion, national origin, source of premium revenue, height, weight, disability or health status; (b) preserve and enhance the dignity of Members; (c) provide or refer Members for instruction in personal health measures, when deemed appropriate under the particular circumstances; (d) prescribe or direct other patient

education for Members, when deemed appropriate; and (e) refer Members for medical social services assistance, when deemed appropriate.

2.22 DMC Locations. DMC shall deliver Covered Services to Members at those DMC Participating Hospital locations approved by Plan, with such amendments or modifications as the parties may mutually agree upon from time to time. The DMC shall notify Plan at least sixty (60) days prior to making any addition or change in location. Plan shall have the option to terminate the DMC's participation in the Products upon thirty (30) days written notice to the DMC if, in its sole discretion, Plan determines that an addition to or change in hospital locations is not in the best interest of the Members.

ARTICLE 3
PLAN RESPONSIBILITIES

3.1 Member Identification. Plan shall maintain a current eligibility data system and mechanism for the DMC to verify eligibility of Members as provided in the Plan Provider Manual. Each Member will be given an identification card for the Plan, but the presentation of the card is not evidence of entitlement to Covered Services. DMC recognizes that the eligibility data available to Plan is provided by unrelated parties, hence Plan may not be held accountable for any errors or omissions as it pertains to Member's eligibility, especially where retroactive disenrollment is permitted and has occurred under the Products. In these cases of retroactive disenrollment, Plan is not responsible for payment and the individual patient or other appropriate payor may be billed by the DMC.

3.2 Determination of Covered Services. Plan will provide the DMC with a schedule of Covered Services for each relevant Product and will notify the DMC of any amendments or modifications to such schedules. Plan shall be responsible for the determination of the extent of coverage for a Member under the Products. The DMC acknowledges and agrees that the DMC has an independent responsibility to provide medical care to Members and that any action by Plan pursuant to its utilization review, referral management, or discharge planning programs shall not absolve the DMC of the responsibility to provide appropriate medical care to Members.

3.3 Quality Programs. Plan shall conduct its Quality Assurance programs, Utilization Management programs and peer review and other related quality programs as described in the Plan Provider Manual.

3.4 Member Services. Plan shall provide those services to Members described in the Plan Provider Manual, including processing of complaints and grievances, and preparation and dissemination of informational packages to Members to explain how Covered Services are arranged by Plan and delivered by the DMC in a timely manner.

3.5 Appeals Process. Plan shall maintain a grievance procedure for Members and a provider appeal process as described in the Plan Provider Manual.

ARTICLE 4
BILLING AND COMPENSATION

4.1 Compensation to the DMC. In consideration of DMC's performance of the terms and conditions of this Agreement, Plan agrees to reimburse in accordance with the capitated rates and payment terms set forth in the Section 4.1.1 and 4.1.2 referenced below. DMC expressly agrees that DMC will not claim payment in any form from any state agency for items or services furnished to Medicare or Medicaid qualified beneficiaries in accordance with this Agreement, except as approved by the state health care program.

4.1.1 Capitation. For Covered Services provided to all Members assigned to the Participating Centers set forth in Schedule 1.20 (Participating Centers), the DMC shall receive a Capitation payment as described in Schedule 4.1 (Compensation). Capitation payments shall be made by the fifteenth (15^{th}) business day of the month for which payment is being made. Interest at prime rate plus 1% will be charged if payments to the DMC are received more than thirty (30) business days past the due date. The Capitation shall include all Covered Services rendered to those Members, including Emergency Services as more fully described in Schedule 4.1 (Compensation).

4.1.2 Fee For Service. For Covered Services provided to Members not assigned to one of the Participating Centers, Plan will compensate the DMC at the rates set forth in Schedule 4.1 (Compensation).

4.2 Condition of Payment. DMC, as a condition of receiving payment for Covered Services rendered in accordance with the terms of this Agreement, shall ensure that (a) the services provided to a Member were Covered Services; (b) the Covered Services were authorized under policies and procedures acceptable to Plan; (c) the Covered Services to a Member were Medically Necessary; (d) a properly completed Clean Claim for Covered Services was received by Plan no later than the date required under this Agreement or, for Capitation payments, that the properly completed encounter data was timely received by Plan in accordance with Plan's policies and procedures; and (e) the individual receiving Covered Services was a Member.

4.3 Copayments. The DMC shall establish a mechanism and be responsible for the collection of all Copayments, Coinsurance or reasonable deductibles, where applicable, pursuant to the Certificate of Coverage.

4.4 No Inducement. The DMC expressly acknowledges and agrees no specific payment is being made directly or indirectly for the Products as an inducement to reduce or limit Medically Necessary services provided with respect to a Member enrolled with Plan.

4.5 Denial of Payment. Plan, where applicable, has the right to deny payment to a DMC for services which Plan determines are not rendered in accordance with this Agreement.

4.6 Coordination of Benefits. Plan and the DMC shall be responsible for the coordination of benefits and shall use their best efforts to collect primary insurance coverage and enforce

rights of subrogation, if any. The DMC shall be responsible for obtaining information from Member of other insurance coverage and shall communicate it to Plan.

4.7 Security in Electronic Transmissions. The parties agree that the integrity and confidentiality of all data electronically exchanged between them shall be protected and maintained in accordance with all applicable laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and all rules promulgated thereunder.

4.8 Transaction and Code Sets Standards. The parties shall comply with all federal and state laws regarding the submission of electronic transactions in standard formats with standard data elements, including HIPAA and any state implementing requirements. The parties agree to enter into any necessary agreements, including trading partner agreements, when applicable, for compliance with those laws.

4.9 Government Suspension/Reduction in Payments. Any suspension in the federal government's payment to Plan through no fault of Plan or any reduction in the federal government's payment rate to Plan pursuant to the Products during Plan's contract year shall, at the option of Plan, result in a suspension or proportional reduction in the DMC's reimbursement for Members who are receiving Covered Services in connection with Products. Such governmental action could include, but is not limited to, the sequestration of federal funds by either United States Congress or the Federal Executive Branch, an increase in the Medicare benefits package without a commensurate increase in the payment rate to Plan, or any other unilateral change that adversely affects Plan's compensation under the Products.

4.10 Provider Incentive Arrangements. To comply with the rules regulating provider incentive plans, Plan and the DMC agree to review the payment arrangements set forth herein to comply with those regulations, if applicable. If such arrangements fall within the definition of incentive payments that place this Agreement within a provider incentive plan listed in 42 CFR 417.479, the parties shall provide disclosures as required and shall comply with the applicable regulations.

ARTICLE 5
HOLD HARMLESS PROVISIONS

5.1 Member Hold Harmless. The DMC shall look only to Plan for compensation for Covered Services rendered to a Member under the Products. DMC agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Member or persons acting on behalf of Member (other than Plan), except to the extent that Copayments, Coinsurance or deductibles are specified in the Products or as permitted under the Coordination of Benefits Policy of Plan. The DMC agrees not to maintain any action at law or in equity against a Member to collect sums that are owed by Plan to the DMC under the terms of this Agreement, even in the event Plan fails to pay, becomes insolvent or otherwise breaches the terms and conditions of this Agreement. This Section shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Members. This Section is not intended to apply to services provided after this Agreement has been terminated, except as provided in those agreements, or to Noncovered Services. The DMC

further agrees that this provision supersedes any oral or written agreement, hereinafter entered into between the DMC and Member or persons acting on Member's behalf, insofar as such agreement relates to payment for services provided under the terms and conditions of this Agreement.

5.2 Continuation of Benefits. The DMC agrees that in the event of Plan's insolvency or other cessation of operations, benefits to Members will continue through the period for which Plan has received a premium, and benefits to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Member is discharged. The DMC agrees that this Section 5.2 shall survive the termination of this Agreement, regardless of the reason for termination, including the insolvency of Plan, and shall be construed to be for the benefit of Plan's Members. The DMC agrees that this Section 5.2 supersedes any oral or written contrary agreement now existing or hereafter entered into between the DMC and Members or persons acting on their behalf insofar as such contrary agreement relates to liability for continuation of Covered Services provided under the terms and conditions of this Section 5.2.

ARTICLE 6
INSURANCE AND INDEMNIFICATION; RELATIONSHIP OF PARTIES

6.1 Insurance. The DMC or its DMC Participating Hospitals shall maintain policies of professional and general liability insurance coverage or self-insurance in amounts acceptable to Plan, as shall be necessary, to insure the DMC and each DMC Participating Hospital and their directors, officers, employees or agents against any claims or claims for damage arising by reason of personal injury or death occasioned by the DMC and the DMC Participating Hospitals' performance hereunder. Such policies shall be in limits of not less than those stated in Section 6.1.1 below. The DMC shall provide copies of applicable certificates of insurance or evidence of self-insurance upon Plan's request.

6.1.1 DMC Insurance. Each DMC Participating Hospital shall maintain adequate professional and general liability insurance coverage or self-insurance acceptable to Plan in amounts not less than One Million ($1,000,000.00) Dollars per occurrence and Three Million ($3,000,000.00) Dollars annual aggregate.

6.1.2 Participating Provider Insurance. Each Participating Physician on staff at DMC and its DMC Participating Hospitals shall be required to maintain adequate professional and general liability insurance coverage in amounts not less than One Hundred Thousand ($100,000.00) Dollars per occurrence and Three Hundred Thousand ($300,000.00) Dollars annual aggregate from a carrier acceptable to Plan.

6.2 Notice. The DMC shall provide Plan notice of any cancellation or adverse changes to such insurance coverage described in this Article 6 at least thirty (30) days prior to, but in no event, later than upon notification of such cancellation or adverse change.

6.3 Plan Insurance. Plan, at its sole cost and expense, shall procure and maintain policies of general liability and professional liability, as shall be necessary, to insure Plan and its officers,

employees or agents against any claim or claims for damages arising by reason of personal injury or death occasioned directly or indirectly with Plan's performance under this Agreement, including, but not limited to, the provision of any services by Plan, or activities of Plan. Such policies shall be in limits of not less than One Million ($1,000,000.00) Dollars per occurrence and Three Million ($3,000,000.00) Dollars annual aggregate. The Plan shall provide copies of applicable certificates of insurance or evidence of self-insurance upon DMC's request. The Plan agrees to notify the DMC immediately upon notification from an insurance carrier that its policies may be cancelled, terminated, or otherwise adversely modified.

6.4 Indemnification. The purpose of this section is to define and clarify the responsibilities of each of the parties with respect to liability which may be imposed solely by reason of the activities of the DMC and Plan relating to this Agreement. It is not the intent of the parties to incur by contract any additional liability for the negligent operations, acts, or omissions of the other party or its agents or employees. Rather, as set forth hereinafter, each of the parties hereto assumes full responsibility for the negligent operations, acts, and omissions of its own employees, agents, and contractors; and each party hereto seeks indemnification only against the negligent operation, acts, and omissions of the employees, agents, or contractors of the other party.

6.4.1 The DMC shall indemnify and hold harmless Plan against any and all liability for injury, loss, claims, or damages arising from the negligent operations, acts, or omissions of the DMC, its employees, agents, and contractors while engaged in activities within the scope of this Agreement. Furthermore, The DMC shall indemnify and hold harmless Plan against all costs and expenses, including but not limited to, reasonable legal expenses, which are incurred by or on behalf of Plan in connection with the defense of such claims.

6.4.2 Plan shall indemnify and hold harmless the DMC against any and all liability for injury, loss, claims, or damages arising from the negligent operations, acts, or omissions of Plan, its employees, agents, and contractors while engaged in activities within the scope of this Agreement. Furthermore, Plan shall indemnify and hold harmless the DMC against all costs and expenses, including but not limited to, reasonable legal expenses, which are incurred by or on behalf of the DMC in connection with the defense of such claims.

6.4.3 In the event that a court of competent jurisdiction makes a final determination in a case that Plan and the DMC share the liability for all or part of any injury, loss, or claim for damages by a third-party (or an agent or employee of the parties hereto), each party shall bear its respective comparative negligence share of the damages, and each party shall also pay its own respective costs and expenses incurred as a co-defendant. Where there has been no formal finding of comparative negligence as between Plan and the DMC, including claims settled out of court, the parties agree to arbitrate their comparative negligence. The parties shall then arbitrate their differences between themselves, or agree upon a mutually acceptable arbitration procedure.

6.5 Independent Contractors. None of the provisions of this Agreement are intended to create any relationship between the parties, including, but not limited to, employer and employee, principal and agent, partner, or joint venturer, other than that of independent parties

contracting with each other solely for the purpose of effectuating the provisions of this Agreement. None of the parties hereto nor any of their respective representatives, employees, or agents, is the agent, employee or representative of the other. The relationship between Plan and the DMC is that of purchaser and providers of health care services, respectively. Nothing in this Agreement shall affect DMC's obligation to exercise independent medical or professional judgment as required by prevailing professional standards of care.

ARTICLE 7
NONDISCLOSURE OF INFORMATION

7.1 Confidentiality. The DMC understands that the DMC will have access to confidential and proprietary information of Plan while rendering services under this Agreement. Confidential and proprietary information (collectively "Information") shall include, but not be limited to, all correspondence, drawings, notes, letters, notebooks, reports, flow charts, data, projections, programs, proposals, manuals, customer lists, tax records and any and all documents concerning Plan or its clients or any documents concerning procedures developed by or used by Plan, either in writing or verbally, except (a) Information which, at the time of disclosure, is in the public domain by publication or otherwise through no fault or action by the DMC, or (b) Information which was received by the DMC from a third party having the legal right to transmit that Information. The DMC shall not disclose nor divulge any of the Information of Plan disclosed to the DMC or developed by the DMC in connection with the relationship between the DMC and Plan. This provision shall not prevent the DMC from discussing treatment options or medical conditions with Members regardless of whether coverage is provided by Plan. This provision shall survive termination of this Agreement.

7.2 Limitation on Use of Plan's Information. The DMC shall not reproduce or make copies of the Information of Plan, except as required in the performance of services hereunder. Upon termination of this Agreement for any reason whatsoever and upon Plan's request, the DMC shall promptly deliver to Plan all Information, and any and all other documents and materials used by the DMC together with any reproductions made by DMC or in the possession of the DMC. The DMC understands and agrees that all such Information, whether developed by the DMC or others, is and shall remain, the property of Plan. This provision shall survive termination of this Agreement.

ARTICLE 8
RESOLUTION OF DISPUTES

8.1 Disputes. Any dispute or question arising between Plan and the DMC or any other party or parties hereto involving the application, interpretation, or performance of this Agreement shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation. The parties shall negotiate all matters of joint concern in good faith, with the intention of resolving issues between them in a mutually satisfactory manner. Only disputes within the scope of this Agreement are subject to

this Section 8.1. However, nothing in this Section shall preclude the parties from exercising their termination rights pursuant to Section 11 (Termination).

8.2 Informal Resolution. If a dispute arises under this Agreement, then within ten (10) business days after a written request by either party, Plan's CEO, or his/her designee, and the DMC's CEO, or his/her designee, shall promptly confer to resolve the dispute. If these representatives cannot resolve the dispute or either of them determines they are not making progress toward the resolution of the dispute within twenty (20) business days after their initial conference, then the dispute shall be submitted to non-binding mediation or facilitation. If mediation or facilitation cannot resolve the dispute within ninety (90) days, then the parties shall be free to pursue their legal remedies. The parties agree all statements made in connection with internal dispute resolution efforts shall not be considered admissions or statements against interest by either party. The parties further agree that they will not attempt to introduce such statements at any later trial, arbitration, or mediation between the parties. Each party shall be responsible for its own costs of informal resolution unless otherwise agreed to between the parties.

ARTICLE 9
RECORDS

9.1 Medical Records. DMC shall cause its DMC Participating Hospitals and their employees and agents hereunder to complete and maintain appropriate medical records in accordance with applicable state and federal laws, applicable accrediting agencies, Plan requirements and customary medical practice. Medical records shall be legible and reflect all aspects of patient care. The DMC shall permit access to medical records to Plan or state or federal authorities and their agents including, but not limited to, Department of Health and Human Services, CMS and Michigan Department of Community Health, involved in assessing the quality of care, investigating grievances, performing credentialing activities or determining compliance with this Agreement and the Plan Provider Manual. The DMC shall maintain medical records relating to Members for the greater of six (6) years or the period required under applicable state or federal law to maintain patient records. Notwithstanding termination of this Agreement for any reason, this provision shall survive the termination of this Agreement.

9.1.1 Transfer and Confidentiality. The DMC agrees to cooperate in the transfer of copies of the Member's medical records to other Participating Providers or health care providers. The DMC agree that each Member's medical records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records. The DMC shall not disclose medical information of Members without prior written consent or as otherwise required by law. Notwithstanding termination of this Agreement for any reason, this provision shall survive the termination of this Agreement.

9.1.2 HIPAA Privacy Requirements. The DMC represents and warrants that it is a "Covered Entity" as defined by the regulations, Standards for Privacy of Individually Identifiable Health Information, promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") on the effective date of those regulations and is familiar

with the requirements therein. In the course of performing its duties and obligations under this Agreement, the DMC will receive or create certain information concerning Members of the Plan that constitute "Protected Health Information" within the meaning of the HIPAA regulations ("PHI"). With respect to disclosures of PHI by a Covered Entity, such as Plan, to a health care provider concerning the treatment of the individual or payment, as is contemplated by this Agreement, an exception to the business associate requirements of the HIPAA regulations is created. For any other use and/or disclosure of protected health information pursuant to this Agreement, whether as a Covered Entity or a Business Associate (as that term is defined in HIPAA), the DMC shall be in compliance with the HIPAA regulations and any such violation shall be a material breach of this Agreement. Further, the DMC shall execute any written documents required by Plan in compliance with the HIPAA regulations.

9.2 Access to Records. In the event that the Secretary of Health and Human Services or the Comptroller General of the United States or their representatives determine that this Agreement is a contract as described in Section 1861(v)(1)(1) of the Social Security Act, DMC agree that until the expiration of four (4) years after the furnishing of services pursuant to this Agreement, DMC shall make available, upon written request, to Plan or the Secretary of Health and Human Services, or upon request of the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement, and books, documents and records of the DMC that are necessary to certify the nature and extent of costs paid by Plan pursuant to this Agreement. If the DMC carries out any of the duties of this Agreement through a subcontract with a value or cost of $10,000 or more over a twelve (12) month period with a related organization as defined in 42 CFR 405.427, such subcontract shall contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the related organization shall make available, upon written request to Plan or the Secretary of Health and Human Services, or upon request to the Comptroller General of the United States, or any of their duly authorized representatives, the subcontract, and books, documents and records of such organization that are necessary to verify the nature and extent of such costs.

ARTICLE 10
MARKETING

10.1 Marketing. During the term of this Agreement, Plan may use the DMC's and each DMC Participating Hospital's name, address and description of specialized services for purposes of informing Members of the identity of the DMC and otherwise carrying out the terms of this Agreement. Likewise, the DMC shall have the right to inform the public that they participate in Plan's Products. Any promotional material pertaining to products or Covered Services which is to be used by the DMC, but is not received directly from Plan, must be approved by Plan in writing prior to its use.

10.2 No Solicitation. During the term hereof and for a period of one-year after termination or expiration of this Agreement, the DMC shall not solicit any Member or Subscriber group of Plan to either disenroll from Plan or to use a different health care benefits insurer.

10.2 Names, Symbols, Trademarks and Service Marks. Plan and the DMC each reserve all rights to their own name and all symbols, trademarks and service marks presently existing or later established. In addition, except as provided herein, no party shall use any other party's name, symbols, trademarks or service marks or the name, symbol, trademark or service mark of any entity affiliated with a party hereto, without the prior written consent of that entity and shall cease any such usage immediately upon written notice from that entity.

ARTICLE 11
TERM AND TERMINATION

11.1 Term and Renewal. This Agreement shall be effective for a term commencing August 1, 2001 and continuing to December 31, 2005, unless earlier terminated in accordance with this Section 11 (Term and Termination). Notwithstanding the foregoing term, in the event the parties to this Agreement are renegotiating a new agreement during or after the expiration of this Agreement, the parties agree that the terms of this Agreement shall apply until the parties execute a new agreement, as evidenced by a written instrument with both parties' signatures.

11.2 Termination Without Cause. This Agreement may be terminated by either party without cause at any time upon one hundred fifty (150) days prior written notice.

11.3 Termination Upon Breach. This Agreement may be terminated by Plan or by the DMC, upon thirty (30) days prior written notice to the other, for cause, including a material breach of this Agreement. Any such termination(s) shall be effective if the other party has failed to cure the breach prior to the expiration of the thirty (30) days following receipt of such written notice, unless the cure period is extended by mutual agreement of the parties.

11.4 Immediate Termination by Plan. Plan may terminate this Agreement with the DMC or with an individual DMC Participating Hospital immediately if (a) a DMC Participating Hospital lacks a qualification as required by this Agreement; (b) when, in the sole discretion and judgment of Plan, Plan determines that immediate termination is in the best medical interest of the Members to prevent harm to the Members; or (c) a DMC Participating Hospital fails to perform the professional duties required hereunder. The DMC and/or its DMC Participating Hospital shall cease rendering care to Members in the event of an immediate termination by Plan pursuant to this Section. Such individual DMC Participating Hospital termination shall not operate to terminate this Agreement with respect to the DMC or other DMC Participating Hospitals if set forth in writing by Plan.

11.5 Immediate Termination by the DMC. The DMC may terminate this Agreement immediately if Plan fails to maintain any license which is a condition precedent to the performance of its duties and obligations hereunder or if Plan fails to make two (2) consecutive capitation payments to the DMC within thirty (30) days of the due date.

ARTICLE 12
GENERAL PROVISIONS

12.1 Non-Assignability. Neither the Plan nor Provider shall have the right to assign this Agreement or transfer any of their respective duties and responsibilities under this Agreement without the prior written consent of the other party. The Plan and Provider hereby agree that approval of a request for assignment will not be unreasonably withheld.

12.2 Amendment. No amendment to this Agreement or its schedules shall be effective unless in writing and signed by the parties hereto. The Plan may, however, amend its policies at any time during the term by giving sixty (60) days prior written notice to the DMC of the proposed policy amendment. In the event a policy amendment is not acceptable to the DMC, the DMC may terminate participation in this Agreement by giving written notice to Plan in accordance with Section 11.2 (Termination Without Cause) prior to the effective date of the policy amendment. The DMC shall be deemed to have accepted such policy as of the effective date thereof if Plan has neither received a written objection to the amendment or if the DMC has not given written notice of without cause termination.

12.3 No Waiver. The waiver by either party of a breach or violation of any one provision of this Agreement shall not be deemed a waiver of any other breach of the same or different provision. No failure or delay by any party in exercising any right hereunder will operate as a waiver thereof.

12.4 Notices. All notices must be in writing and delivered either personally or sent by registered or certified mail, return receipt requested, postage prepaid, to the following addresses:

If to the DMC:
Detroit Medical Center
3990 John R.
1 Harper-Brush South
Detroit, Michigan 48201
Attn: Senior Vice President, Managed Care

If to Plan:
OmniCare Health Plan
1155 Brewery Park Blvd., Suite 250
Detroit, Michigan 48207
Attn:Chief Executive Officer

Notice is effective when received, if by personal service, or three (3) business days after mailing, if by registered or certified mail.

12.5 Severability. In the event any provision of this Agreement is rendered invalid or unenforceable by law or any court of competent jurisdiction, such provision shall be severable and the remainder of the provisions of this Agreement shall remain in full force and effect. If the severable provision has the effect of materially altering the obligations of either party in such manner as, in the judgment of either party affected, (a) will cause serious financial hardship to

such party or (b) will substantially disrupt and hamper the mutual efforts of the parties to maintain a cost efficient means of delivery of health care services, or (c) will cause such party to act in violation of its corporate Articles of Incorporation or Bylaws, the party so affected shall have the right to terminate this Agreement as it affects such party upon thirty (30) days prior written notice to the other party.

12.6 Headings. The headings of the Sections contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of these agreements.

12.7 Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Michigan and applicable federal law.

12.8 Entire Agreement. This Agreement together with its Schedules, Exhibits and attachments, as are now incorporated, constitute the entire understanding and agreement of the parties hereto and supersede any prior written or oral agreement pertaining to the subject matter hereof.

IN WITNESS WHEREOF, the parties, intending to be legally bound, have set forth their signatures on the dates set forth below.

THE DETROIT MEDICAL CENTER

By: _____

Its: CEO

Dated: 9-23-02

APPROVED BY LEGAL AFFAIRS

OMNICARE HEALTH PLAN

By: _____

Its: Deputy Rehabilitator

Dated: 9/24/02

SCHEDULE 1.9 (COVERED SERVICES)

All inpatient/outpatient facility services billed on a UB92 claim form including anesthesiology, radiology, pharmacy, surgery, diagnostic testing, preadmission testing within 96 hours of an authorized inpatient/outpatient stay, emergency or urgent care visit, all as further set forth in the Provider Manual. Emergency facility services for Medicaid Members includes Medical Screening Exams performed under EMTALA.

Exclusions: Outpatient laboratory services, inpatient and outpatient psychiatric services, nursing and extended care, hospice, renal dialysis and others as set forth in the Provider Manual.

SCHEDULE 1.10 (DMC PARTICIPATING HOSPITALS)

- Sinai-Grace Hospital
- Harper -Hutzel Hospital
- Detroit Receiving Hospital
- Children's Hospital of Michigan
- Huron Valley - Sinai Hospital
- Rehabilitation Institute of Michigan

SCHEDULE 1.20 (PARTICIPATING CENTERS)

Effective 8/1/01

127 - Novi Health Care Centers
128 - Detroit Health Care Centers
129 - Woodland Health Care Center
168 - Primary Care Clinics
172 - Primary Care Clinics
173 - Primary Care Clinics
174 - Primary Care Clinics
175 - Primary Care Clinics
176 - Primary Care Clinics
178 - Primary Care Clinics
2024 - Coordinated Health Care
2037 - W. Davison Health Care Center
2038 - E. 7 Mile Health Care Center
2044 - Affiliated Internists, P.C.
2045 - University Women's Care
2046 - University Pediatricians
2047 - DMC Centers, Inc.

Added effective 10/01/01

20 - Professional Plaza Health Center
75 - Associated Health Care Center
113 - Seven Greenfield IPA
151 - Virginia Park Medical Center
183 - Howard Medical Clinic
187 - Betts Medical Center, PC
2036 - Andrew J. Smith, MD Memorial Group
2055 - University Family Physicians

SCHEDULE 2.2.1 (DELEGATED ACTIVITIES)

None.

SCHEDULE 2.3.1 (Procedures For Authorization)

Procedures for Authorization For the Delivery of Hospital Services

The following procedures should be followed when a Member requires hospitalization or outpatient Covered Services to ensure payment to the facility providing that medical care.

Elective Admissions and Outpatient Surgical Procedures

A seven-digit authorization number issued by the Plan must be obtained (by telephone) on the date of service at the time the patient arrives for the service. If the patient presents himself for admission Monday through Friday during regular office hours (8:30 a.m. - 5:00 p.m.), please phone Hospital Utilization. At any other time, please follow the procedures outlined in the Plan Provider Manual.

The Plan will not pay for elective admissions which have not been authorized in advance.

Note: Pre-admission testing does not require an authorization number. However, it must be conducted within ninety-six (96) hours prior to the surgery. If the pre-admission testing is done and the surgery is postponed or canceled, it is necessary for the hospital to obtain an authorization number for the pre-admission testing in order to receive payment for that service.

Emergency Inpatient Admissions and Outpatient Emergency Surgery

Emergency room services that result in an inpatient admission and/or outpatient emergency surgery require a seven-digit authorization number issued by the Plan. Not later than the next day after an emergency admission has occurred, the Hospital agrees to contact the Plan to secure an appropriate authorization number.

If the patient presents himself for admission Monday through Friday during regular office hours (8:30 a.m. - 5:00 p.m.), please phone Hospital Utilization. At any other time, follow the procedures outlined in the Plan Provider Manual.

Outpatient Diagnostic Testing and Therapy

Outpatient diagnostic testing and therapy do not require an authorization but rather a referral from a Plan physician who will issue the "OmniCare Consultation and Referral Form" or similar form. It is necessary to obtain a referral in order to receive payment for that service. The individual should present this form to the hospital at the time service is to be provided. Please submit the billing portion of this form to:

OmniCare Health Plan
Claims Department
1155 Brewery Park Boulevard, Suite 250
Detroit, Michigan 48207

The following services are included in this category but do not make up the entire list of procedures for which a referral is required:

1. Routine X-ray
2. Routine Laboratory
3. Occupational Therapy
4. Speech Therapy
5. Physical Therapy
6. Chemotherapy
7. Cobalt/X-ray

Emergency Room Services

Emergent services rendered in the emergency room do not require preauthorization. The Plan will pay for these services for Plan Members provided the condition meets the Plan definition of Emergency Services.

Non-Emergency Treatment Requested at the Emergency Room

In cases in which a Member presents himself/herself at the emergency room requesting services that are not of an emergency nature, and the Hospital does not have an agreement with the Plan for the provision of Urgent Care and/or Triage Services, the Member should be advised to call the Plan. The Member may then be referred to an approved Plan facility that can provide appropriate non-emergency treatment.

Services Rendered to Members Not Identified to Provider

It is recognized that there may be cases, on rare occasions, in which the Hospital may render services to a person who is not known to be a Member at the time of service. It is understood that the Plan shall pay for such services if the hospital notifies the Plan and obtains verification of entitlement to Covered Services as soon as possible after discovering that the person is a Member entitled to the Covered Services of the Plan.

Admissions Through the Emergency Department

In the case of Hospitals that are paid by the Plan on a DRG or a per diem basis for inpatient services, the following policy applies:

> For Members who have received services in the emergency department and are subsequently admitted to that Hospital, the Plan, will not be responsible for the payment of services rendered in the emergency department. These services are included in the first day's per diem or DRG.

Plan Members and Motor Vehicle Accidents

When a Member, enrolled through a commercial account, is injured in a Motor Vehicle Accident (MVA) and there is "Full Medical Coverage" through the auto carrier, Plan will reject the entire amount because the auto carrier is primary. If the Member is covered under a "Coordinated Policy" with the auto carrier, Plan will pay the Hospital 80% of the amount due under the existing contract rate. Any outstanding balances should

be billed to the auto carrier. If the Hospital receives a denial of coverage from the auto carrier, it shall forward that denial to Plan and Plan will be responsible for the entirety of Plan's obligation for payment.

For Members who are enrolled through Medicaid Title XIX, Plan assumes no liability if there is an automobile policy that is active on the date of accident. All claims of Medicaid Members covered by active auto policies will be rejected and should be submitted to the auto carrier. Plan will only assume its responsibility for the claim if the application for coverage by the Medicaid Member is rejected by the Assigned Claims Facility.

Workers' Compensation

If a Plan Member is injured on the job and is receiving Workers Compensation, the claim will be rejected, and the Member's employer should pay the claim. If the case is disputed, the Plan will pay the claim initially, and place a lien on the settlement in order to recover expenses.

Coordination of Benefits

In those instances where Plan has issued a valid authorization for services rendered by the Hospital and the Hospital provides the Plan with a denial from the alternate payor(s), the Plan will reimburse the Hospital for the authorized services at the contracted rate.

In the event that the Plan verifies the eligibility of a Member and authorizes covered services, and it is subsequently determined that the Plan is not primary, the Plan shall notify the Hospital that the claim will not be paid. The Plan will notify Hospital of the responsible party if such information is available and shall assist Hospital in securing payment from the responsible party.

For dependents of Members with multiple commercial coverages, the Plan has the following policy:

1. If both carriers have COB clauses, the carrier covering the patient as a Subscriber will have primary responsibility.

2. If both carriers cover the dependent, the carrier covering the dependent of the Member whose birthday comes first in the calendar year will be the primary carrier.

3. If the parents' birthdays happen to fall on the same day, then the Member whose plan has been in effect the longest will be primary.

These scenarios apply to private market Member only. In the case of a public market Member, any/all other existing carriers are primary over the Plan. Title III & XIX of the Social Security Act mandates that all resources, public and private, for the payment of medical expenses are primary to Medicaid and Medicare.

Authorizations for Newborns

Newborns and mothers are covered by the same authorization while simultaneously confined in the same facility. An additional authorization is required for border babies. (any newborn that remains in the hospital after the mother's discharge) and any newborn that is transferred to another facility post birth.

False Labor

Health Plan's policy is that claims submitted for the following pre-delivery services will be reimbursable as an emergency service, when properly supported by the emergency room or Labor & Delivery report. The services are:

Diagnosis Description
Threatened Premature Labor
False Labor (Other Threatened Labor NOS)
Threatened Abortion

Please note that these exact terms should be shown on the claim, as should these specific diagnosis codes. In addition, the diagnosis must be the PRIMARY DIAGNOSIS. No Consultation Referral Form is required. These claims will be paid at the same rate of emergency services, as determined by the facilities contractual arrangement with the Plan. Claims which are submitted for other types of prenatal services will be rejected by the Plan if they do not have a Consultation Referral Form or similar form.

SCHEDULE 4.1 (COMPENSATION)

A. CAPITATION

1. **Capitation Payment**. As compensation for Covered Services for Medicaid and Commercial Members described below, Plan shall make monthly Capitation payments to the DMC based on the number of Members assigned to the Participating Centers who are eligible to receive Covered Services. Initially, the monthly Capitation rate shall be sixty ($60.00) dollars per member per month. Effective April 1, 2002, the monthly capitation rate for Commercial Members shall be fifty-seven ($57.00) dollars per Member per Month, and the monthly Capitation for (a) Aid to Families with Dependent Children ("AFDC") Members shall be forty ($40.50) dollars and fifty cents per AFDC Member per month, and (b) Assistance to the Blind or Disabled ("ABAD") Members shall be two hundred ($200.00) dollars per ABAD Member per month. The DMC shall accept such Capitation as payment in full for Covered Services rendered during that month to Members assigned to the Participating Centers less the Withhold stated below. The above Medicaid Capitation rates were derived applying projected utilization to the Medicaid DRG and per diem rates as set by the State of Michigan. Any changes in Medicaid DRG and per diem rates will be reflected as an adjustment to the Medicaid Capitation rates, effective concurrently with the date such changes are made by the State of Michigan.

2. **Withhold**. Plan shall withhold amounts stated herein from the Capitation payments made to the DMC (the"Withhold") and shall maintain those funds in a Plan bank account ("Withhold Fund"). The Withhold Fund is used to pay for and shall be debited for the following: (a) Non-emergency Covered Services rendered by non-DMC Participating Hospitals during that month to Members assigned to the Participating Centers; (b) Emergency Services rendered by non-DMC Participating Hospitals and Nonparticipating Providers, whether in network or out of network, to Members assigned to the Participating Centers; and (c) Non-emergency Covered Services rendered by Non-Participating Hospitals with prior authorization from the DMC during that month to Members assigned to the Participating Centers (a, b, and c herein collectively referred to as the "Out-of-Network Costs").

2.1 Withhold Prior to April 1, 2002. Plan shall withhold ten (10%) percent of the Capitation payment payable to the DMC hereunder during the period August 1, 2001 to September 30, 2001, and fifteen (15%) percent beginning October 1, 2001 to March 30, 2002. Plan shall maintain an accounting of the Withhold in accordance with this Agreement. The DMC shall be solely responsible for all Out-of-Network Costs up to the Withhold amount. Out-of-Network Costs in excess of the Withhold Fund will be the sole financial responsibility of the Plan.

2.2. Withhold Effective April 1, 2002. Plan shall withhold twenty (20%) percent of the Capitation payment payable to the DMC hereunder beginning April 1, 2002 through the end of the term. The DMC shall be solely responsible for all Out-of–Network Costs up to the Withhold amount. Out-of-Network Costs exceedingthe Withhold Fund will be the sole financial responsibility of Plan.

2.3 Settlement. At the end of each contract year, Plan shall reconcile the amounts in the Withhold Fund with the actual amounts paid and payable in accordance with this Schedule during the contract year. The first reconciliation shall occur after six (6) months of claims run-off and the second and final reconciliation shall occur after twelve (12) months of claims run-off. Plan shall complete the final reconciliation within sixty (60) days from the end of the year following the end of the contract year (14 months from the end of the contract year). Any Withhold surplus shall be remitted within thirty (30) days of the final reconciliation or adjusted in the next Capitation payment from Plan to the DMC. Claims paid in accordance with this Schedule after the final reconciliation will be debited from the Withhold Fund for the next contract year. For purposes of this provision, the first contract year will be defined as April 1, 2002 through December 31, 2002 and annually thereafter.

3. **CPI Adjustment.** The commercial rates in Section 4.1.A.1. only will be adjusted upward or downward on January 1, 2004 and annually thereafter for a CPI Adjustment. However in no event shall the CPI Adjustment increase or decrease more than a cumulative three (3%) percent annually. "CPI Adjustment" shall mean a percentage adjustment to the commercial Capitation payment specified above in an amount equal to the percentage change in the Consumer Price Index, U.S. City Average-Medical Care (1982-1984=100), published by the United States Department of Labor, Bureau of Labor Statistics ("Index"), based on the percentage difference between the Index published immediately preceding the increase date and the Index published immediately preceding the date on which the CPI Adjustment is to be effective. All adjustments shall be made retroactively to the appropriate date as necessary to account for delays in reporting of the Index. If the Index is changed so that the base year of the Index differs from that specified above, the Index shall be converted in accordance with the conversion factor published by the United States Department of Labor, Bureau of Labor Statistics. If the Index is discontinued or revised during the term, such other governmental index or computation with which it is replaced shall be used in order to obtain substantially the same result as would be obtained if the Index had not been discontinued or revised

B. COMMERCIAL PER DIEM COMPENSATION

For Covered Services rendered to Commercial Members not assigned to Participating Centers and provided that Plan policies and procedures have been met, Plan agrees to reimburse the Hospital for properly submitted and documented Clean Claims within forty five (45) days after receipt of a billing or itemized statement for the Plan Commercial Members who are not assigned to the Participating Centers, provided that the services rendered by the Hospital to such Members were in accordance with the terms of the Agreement and that the billing or statement rendered by the Hospital is in accordance with the terms of the Agreement.

The mechanisms that may be used to compensate the Hospital include:

- Per Diems

INPATIENT SERVICES	COMMERCIAL
• Hospital Inpatient	Blended Rate: (all inclusive meaning all

	ancillary, inpatient charges, x-ray, lab, preadmission testing)
• Medical Surgical (includes Obstetrics mother ** and child and Pediatrics)	$1,535 per day $1,600 (effective September 1, 2002)
• ICU/CCU	$1,565 per day $1,600 (effective September 1, 2002)
• NICU/PCN*	$1,500 per day $1,600 (effective September 1, 2002)
• Boarder Baby ***	$ 700 per day $ 800 (effective September 1, 2002)
• Burn Day	$1,990 per day
• Psychiatric	$ 775 per day $ 800 (effective September 1, 2002)
• All Other Rehabilitation Inst.	$1,050 per day
• Closed Head/Spinal Cord	$1,470 per day

OUTPATIENT SERVICES

• Outpatient Surgery	$2,500 Case Rate
• Emergency Room	$ 300 Case Rate
• Non-Emergent (Urgent Care) (excludes professional services)	$ 75 Case Rate $ 85 (effective September 1, 2002)
• All Other Services	65% of charges

Note: Non-Emergent (Urgent Care) includes Laboratory and Radiology Facility Services.

* Payment for NICU/PCN services commences only upon the discharge of the mother.

** Obstetrical Services includes compensation for both the mother and child as a single unit.

*** Boarder Baby services commence only upon the discharge of the mother.

C. MEDICAID DRG COMPENSATION

For Covered Services rendered to Medicaid Members not assigned to the Participating Centers and provided that Plan policies and procedures have been met, Plan agrees to reimburse the Hospital for properly submitted and documented Clean Claims within forty five (45) days after receipt of a billing or itemized statement for the Plan Medicaid Members who are covered under this Agreement and who are not assigned to Participating Centers, provided that the services rendered by the Hospital to such Members were in accordance with the terms of the Agreement and that the billing or statement rendered by the Hospital is in accordance with the terms of the Agreement.

The mechanisms that may be used to compensate the Hospital include:

- Medicaid DRG Compensation.

- Hospital Specific Base Rate:

Facility Name	Effective 8/1/01
Children's Hospital	$4,232.49
Detroit Receiving Hospital	$4,641.41
Harper-Hutzel Hospital	$4,166.87
Huron Valley Hospital	$4,009.31
Sinai–Grace Hospital	$4,459.29

- The Following Numbers are Provided for Calculation of Rates effective April 1, 2002:

Facility	Base Rate	Capital Add-On	Transfer/Outlier Capital Per Diem
Children's Hospital	$3,932	$ 852	$ 179
Detroit Receiving	$3,894	$ 957	$ 129
Harper/Hutzel	$3,932	$ 384	$ 82
Huron Valley	$3,932	$ 803	$ 208
Sinai-Grace	$3,932	$ 520	$ 92

* Note: The applicable Medicaid DRG and per diem compensation is set by the State of Michigan and any changes made will be applicable to this Schedule 4.1.

The Plan will reimburse Hospital for inpatient services, on a per case basis using Diagnostic Related Groups Methodology (DRG). [1] Cases will be assigned to a DRG using the State's grouper version applicable to the period when the case was discharged from the Hospital. Hospital acknowledges that the Hospital Specific Base Rate is inclusive of base rate, capital, and excludes medical education and disproportionate share compensation (which are the

[1] Rates will be indexed proportionally to the State of Michigan changes in the rate structure paid to the Provider as may occur, but not limited to a State bidding process or HMO rate restructuring.

responsibility of the State of Michigan) and Hospital accepts the per case reimbursement as payment in full, unless there is an outlier for the inpatient medically necessary Covered Services provided to Member. Effective April 1, 2002, reimbursement will be calculated as follows: the hospital–specific Base Rate times the DRG specific weight plus the Capital Add-On.

With the exception of Rehabilitation Covered Services, each inpatient (including newborns) will be assigned DRG Classification and weight. Payment will be computed as follows:

(Hospital Specific DRG Base Rate x DRG Specific Relative Weight)+ Capital Add-on

Outlier cases defined by Medicaid will be paid under Medicaid Outlier Formula, including the Transfer/Outlier Capital Costs Per Diem as described in the table above will be included in calculation of the Medicaid Outlier Formula.

Transfer to a Hospital. Payment to a hospital which receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.

If the client is subsequently discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.

Reimbursement is based on discharge in the following situations if the patient:

- Is formally released from the hospital, or
- is transferred to home health services, or
- dies while hospitalized, or
- leaves the hospital against medical advice, or
- is transferred to a long-term care facility.

If the client is subsequently transferred again, the hospital is paid a DRG daily rate for each day of the client's stay. The payment will not exceed the appropriate full DRG payment plus an outlier payment, if appropriate. Calculation of this payment is as follows: the sum of the Hospital Base Rate times the DRG specific weight divided by the average Length of Stay plus the Transfer/Outlier Capital Costs Per Diem.

Transfers from a Hospital. Except in cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the client's stay, not to exceed the appropriate full DRG payment, plus an outlier payment if appropriate. If the transferring hospital is a specialty hospital (e.g. burn, neonatal) depending on the submitted documentation and a request for "Individual Consideration" or the actual number of days of stay, payment may be a full DRG payment, plus an outlier payment as appropriate.

Rehabilitation services provided at DMC Hospital's distinct unit shall not be paid on a DRG basis and shall be paid at the Medicaid per diem rate as indicated below. This includes Children's, Detroit Receiving and Sinai Hospital's Rehabilitation units.

Facility Name	Effective 8/1/01
Detroit Receiving Hospital	$1,976
Children's Hospital	$1,037
Sinai Hospital	$772
Rehabilitation Institute	$839

- The Following Numbers are Provided for Calculation of Rates effective April 1, 2002:

Facility	Base Rate	Capital Add-On	Total
Detroit Receiving	(deleted)		
Children's Hospital	$ 988	$ 95	$1, 083
Sinai-Grace	$ 922	$ 123	$1,045
Rehabilitation Institute	$ 933	$ 62	$ 995

Note: If a Member is readmitted to the Hospital, within fifteen (15) days following discharge from a hospitalization period, with the same presenting complaints and diagnosis, the readmission will be treated as a continuation of the original stay. In these cases, no additional DRG payment will be made on the second admission. However, outlier payments will be made if applicable. If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment cannot be less than zero for the episode.

Outpatient Services	Medicaid
• Outpatient Surgery	$2,350 Case Rate
• Emergency Room	$ 250 Case Rate
• Non-Emergent (Urgent Care) (excludes professional services)	$ 75 Case Rate
• All other services	60% of charges

*Note: *Non-Emergent (Urgent Care) includes Laboratory and Radiology Facility Services.*

(This provision should be moved to the Omnicare - DMC Provider Agreement for DMC-employed physicians and CRNAs billing separately.)

D. CRNA Fees. For Medicaid Members, the DMC shall be paid at fifty (50%) percent of the Medicaid Fee Schedule for the services rendered by employed CRNAs. For Commercial Members, the DMC shall be paid at fifty (50%) percent of the Plan Fee Schedule for the services rendered by employed CRNAs.

E. Other

Late Charges
Except in regard to claims involving coordination of benefits, any adjustments to claims submitted by Hospital must be filed with the Plan within 180 days of the submission of the original claim or the original claim will be deemed final.

Plan as a Secondary Payor
Plan's fiscal responsibility for claims for which the Plan is the secondary payor is that the total (combined) reimbursement to the Hospital shall be no more than, and no less than, that which the Hospital would have been entitled if the Plan had been the primary payor. Secondary claims must be submitted with the EOB (explanation of benefits) from the primary insurance.

Claims Appeal Process
An appeal should be requested **after** the claim has been initially paid or rejected. Appeals accompanying an initial submission of a claim, with or without documentation will not be considered an appeal. Initial claim submissions will be processed in accordance with claims processing rules.

The appeal must include **sufficient information** to be properly reviewed. The following information, **at a minimum**, should be provided:

- A clear written detailed explanation of why payment should be processed. Note that appeals received without explanation will not be considered.
- Evidence of an earlier rejection from Plan or the primary care physician.
- Medical records when additional money is being requested.
- Medical records when a review is being requested for non-authorized services.

The appeal package should contain the following:
- A detailed explanation as to the reason for the appeal.
- An invoice (UB-92 or AMA-1500)
- Itemized Statement
- Discharge Summary

- Medical Records

The appeal should be submitted to the below address, within 60 days of receipt of the rejection.

OmniCare Health Plan
Attn.: Provider Inquiry Department
1155 Brewery Park Blvd., Suite 250
Detroit, Michigan 48207

Ex. B

Detroit Medical Center
Wayne State University

May 16, 2003

Managed Care

Harper University Hospital
7 Brush
3990 John R
Detroit, MI 48201

Ms. Beverly Allen
Omnicare Health Plan
1155 Brewery Park Blvd. – Suite 200
Detroit, MI 48207

Dear Ms. Allen:

As we discussed previously, the enclosed file contains the DMC services provided to capitated Omnicare members for calendar year 2002. The file is split into the following four components: 1) inpatient Medicaid, 2) outpatient Medicaid, 3) inpatient commercial, and 4) outpatient commercial. A summary financial analysis is also attached.

We made the following assumptions to calculate the fee for service equivalent payment. For inpatient Medicaid we used the 2002 Medicaid DRG reimbursement rate for each DMC hospital plus their capital and outlier payment. For outpatient Medicaid we used the average Medicaid collection rate for each DMC hospital. Calculating the Medicaid fee screen reimbursement amount for each transaction was simply not practicable given the available information. For both inpatient and outpatient commercial we used the average DMC hospital cost to charge ratio. We used this methodology in place of the methodology outlined in the contract to simplify the calculation given the available information. The net amount is approximately the same.

The summary analysis shows that the current capitation rate paid by Omnicare to the DMC is $15.9 million below the amount that DMC would have received from Omnicare had it been paid on a fee for service basis. The summary also shows that the Omni cap is $27.1 million below our cost of providing the service. As you will recall, DMC agreed to help Omnicare when it went into bankruptcy reorganization by accepting a cap amount. **The cap amount was supposed to reflect the amount that DMC would have received had it been getting paid by Omnicare at the Medicaid fee for service rate for Medicaid members and the commercial fee for service rate for commercial members.**

Clearly something is wrong with the current cap arrangement. We may have some members that were not part of the cap included in our calculations. On the other hand our analysis may also be missing some of the services provided to Omnicare capitated members. Omnicare utilization is well beyond what we are experiencing from our other capitated Medicaid health plan and it is well beyond the average Medicaid experience.

Ex. B

Based upon this analysis DMC is requesting an emergency increase in the cap rate as follows:

PROGRAM	OLD RATE	NEW RATE
AFDC	$ 40.50	$ 63.06
ABAD	$200.00	$311.40
OAA	$200.00	$311.40
Commercial	$ 57.00	$ 82.48

I am sure that you have been following the financial trouble that the DMC is currently facing as it is well covered in the news media. When Omnicare was in financial trouble, DMC agreed to help out by accepting a cap arrangement. Now it is the DMC that is facing a financial emergency and we are now asking for your immediate response to our request. Should you have any questions, please contact me at (313) 887-5263.

Sincerely,

Sam Gizzi
Financial Administrator
DMC Health Plans.

Cc: Pat Carlton, Tom Malone, Nick Vitale

OMNICARE
Health Plan

September 17, 2003

Thomas A. Malone, M.D.
Senior Vice President, Managed Care
Detroit Medical Center
3990 John R
Detroit, Michigan 48201

Dear Dr. Malone:

In response to your letter dated July 23, 2003, we are proposing the following financial changes to the current capitation reimbursement being paid to DMC by OmniCare Health Plan.

- We have completed our analysis of the effect of the July 1, 2003 hospital base rate and weight changes. Using historical capitated utilization, the analysis indicates increases in the amount of 3.2% and 1.7% for inpatient AFDC and ABAD, respectively. Applied to the inpatient component of the capitation rate results in an overall increase in the capitation rates of 2.2% and 1.0% for AFDC and ABAD, respectively (see enclosed summary). As such, retroactive to 7/1/2003, we propose to implement the corresponding Medicaid capitation increases consistent with the current contractual language as follows:

Program	Current rate	Revised rate
AFDC	$40.50	$41.41
ABAD	$200.00	$201.94

- On May 1, 2003, the DMC privatized four physician groups. The resulting privatized practice centers were not contemplated in the current hospital capitation agreement however, you have been reimbursed for services provided to the members of these centers under the current capitation rates based upon verbal and electronic correspondence we have had with you. These changes have never been memorialized as an addendum to the current contract. To alleviate the DMC of the excess utilization driven by these practice centers, we propose to reverse the hospital capitation payments made for these privatized Centers and pay all valid claims related to these practice centers under the current fee-for-service contract terms. The Centers are as follows:

2070	2071	2072	2073

In addition to these direct changes, OmniCare is in the process of evaluating and making some delivery system changes which we anticipate will have a positive impact to the DMC when evaluating its contract with OmniCare.

Dr. Malone, I realize that these changes fall short of what you are looking for, however, this represents what we are able to implement at this time. As we discussed earlier, we have also been working diligently on providing information and data to the State of Michigan Department of Community Health ("DCH") with the hopes of obtaining relief for our disproportionate share of members afflicted with HIV/AIDS in Wayne County. Many of the services provided for this population are undeniably provided in DMC facilities. We have petitioned DCH to relieve OmniCare of the risk for these members and move them into the fee-for-service Medicaid environment. Such a change would likewise relieve you of the risk of the high cost of providing services to these members within our capitation contract. We will keep you apprised of any changes as we are notified and the resultant impact on our contract with DMC.

If you have any questions regarding our proposal, please feel free to contact me at (313) 393-8340.

Sincerely,

Beverly A. Allen
Deputy Rehabilitator

Enclosure

cc: Bobby Jones, Deputy Rehabilitator
Judy Weaver, Deputy Commissioner, OFIS

Ex. C

DETROIT MEDICAL CENTER
ANALYSIS OF CAPITATED OMNICARE BUSINESS
HOSPITAL CHARGES & ESTIMATED PAYMENTS
JANUARY - DECEMBER 2002

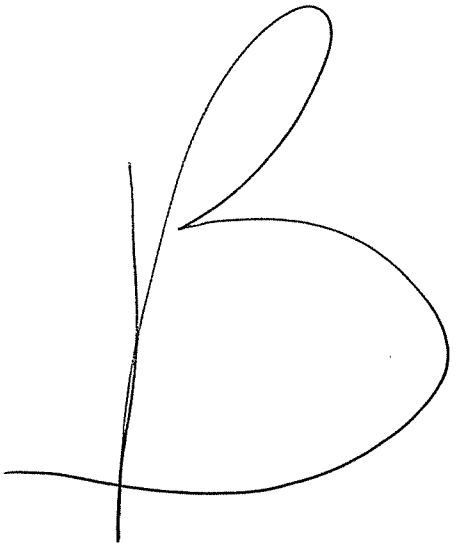
HOSP	DAYS	DEC YTD 2002 INPATIENT CHARGES	2002 FFS RATE	DEC YTD 2002 TOTAL FFS PAYMENT	2002 MEMBER MONTHS	COST RATIO	DEC YTD 2002 TOTAL COST	COST VS MEDICAID FFS	COST VS OMNI CAP
INPATIENT CAPITATED MEDICAID SERVICE					430,420				
				AVG	35,868				
HARPER/HUTZEL	7,396	$ 19,314,383	DRG	$ 9,309,058		49.7%	$ 9,599,248	$ (290,190)	
CHILDRENS	2,457	8,182,757	DRG	3,373,093		49.7%	4,066,830	(693,738)	
DETROIT RECEIVING	3,873	16,315,296	DRG	5,567,562		49.7%	8,108,702	(2,541,140)	
HURON VALLEY	58	214,122	DRG	66,130		49.7%	106,419	(40,289)	
REHAB INSTITUTE	480	1,034,684	PER DIEM	369,600		49.7%	514,238	(144,638)	
SINAI/GRACE	4,662	15,718,171	DRG	5,704,715		49.7%	7,811,931	(2,107,216)	
TOTAL MEDICAID INPATIENT	**18,926**	**$ 60,779,413**		**$ 24,390,158**			**$ 30,207,368**	**$ (5,817,210)**	
OUTPATIENT CAPITATED MEDICAID SERVICE									
HARPER/HUTZEL		$ 14,989,682	38.24%	$ 5,732,054		49.7%	$ 7,449,872	$ (1,717,818)	
CHILDRENS		9,007,373	34.63%	3,119,253		49.7%	4,476,664	(1,357,411)	
DETROIT RECEIVING		5,288,845	26.00%	1,375,100		49.7%	2,628,556	(1,253,456)	
HURON VALLEY		224,843	31.11%	69,949		49.7%	111,747	(41,798)	
REHAB INSTITUTE		507,185	40.33%	204,548		49.7%	252,071	(47,523)	
SINAI/GRACE		7,963,922	36.22%	2,884,533		49.7%	3,958,069	(1,073,537)	
TOTAL MEDICAID OUTPATIENT		**$ 37,981,850**		**$ 13,385,436**			**$ 18,876,979**	**$ (5,491,543)**	
						DISTRIBUTION CAP FFS BASIS			
TOTAL CAPITATED MEDICAID SERVICES									
HARPER/HUTZEL	7,396	$ 34,304,065		$ 15,041,113		$ 9,679,180	$ 17,049,120	$ (2,008,008)	$ (7,369,940)
CHILDRENS	2,457	17,190,130		6,492,346		4,177,921	8,543,495	(2,051,149)	(4,365,573)
DETROIT RECEIVING	3,873	21,604,141		6,942,661		4,467,706	10,737,258	(3,794,597)	(6,269,552)
HURON VALLEY	58	438,965		136,078		87,568	218,166	(82,087)	(130,597)
REHAB INSTITUTE	480	1,541,869		574,148		369,473	766,309	(192,161)	(396,836)
SINAI/GRACE	4,662	23,682,093		8,589,248		5,527,309	11,770,000	(3,180,752)	(6,242,691)
TOTAL MEDICAID	**18,926**	**$ 98,761,263**		**$ 37,775,594**	**$87.76**	**$ 24,309,158**	**$ 49,084,348**	**$ (11,308,754)**	**$ (24,775,189)**
OMNI MEDICAID CAP GROSS				29,972,853	**$69.64**				
OMNI MEDICAID CAP WITHHOLD		.		(5,663,695)	**($13.16)**				
OMNI MEDICAID CAP NET		.		24,309,158	**$56.48**		49,084,348		**$ (24,775,189)**
CAP LESS THAN MEDICAID FFS				**(13,466,436)**	**($31.29)**				

ANALYSIS OF CAPITATED OMNICARE BUSINESS
HOSPITAL CHARGES & ESTIMATED PAYMENTS
JANUARY 1 2003 - DECEMBER 30 2003

HOSP	2003 DAYS	DEC YTD 2003 PATIENT CHARGES	2003 FFS RATE	DEC YTD 2003 TOTAL FFS PAYMENT	YTD MEMBER MONTHS	2003 COST RATIO	DEC YTD 2003 TOTAL COST	COST VS MEDICAID FFS	COST VS OMNI CAP
INPATIENT CAPITATED MEDICAID SERVICE					393,228	32,769			
HARPER	3450	$ 14,391,498	DRG	$ 5,024,483		42.4%	$ 6,101,995	$ (1,077,512)	
HUTZEL	1,940	5,263,968	DRG	1,586,207		42.4%	2,231,922	(645,716)	
KARMANOS	850	3,021,733	DRG	983,065		42.4%	1,281,215	(298,150)	
CHILDRENS	1,903	6,875,073	DRG	2,631,404		42.4%	2,915,031	(283,627)	
DETROIT RECEIVING	3,167	19,275,817	DRG	4,802,798		42.4%	8,172,946	(3,370,149)	
HURON VALLEY	12	49,324	DRG	- 14,509		42.4%	20,913	(6,404)	
REHAB INSTITUTE	609	1,403,766	PER DIEM	468,930		42.4%	595,197	(126,267)	
SINAI/GRACE	3,302	13,382,438	DRG	4,698,270		42.4%	5,674,154	(975,884)	
MEDICAID INPATIENT	15,233	$ 63,663,616		$ 20,209,664	$51.39		$ 26,993,373	**$ (6,783,709)**	
OUTPATIENT CAPITATED MEDICAID SERVICE									
HARPER		$ 8,265,198	39.47%	$ 3,262,274		42.4%	$ 3,504,444	$ (242,170)	
HUTZEL		4,542,132	39.47%	1,792,779		42.4%	1,925,864	(133,084)	
KARMANOS		5,729,845	39.47%	2,261,570		42.4%	2,429,454	(167,884)	
CHILDRENS		9,568,688	37.88%	3,624,619		42.4%	4,057,124	(432,505)	
DETROIT RECEIVING		6,362,081	20.21%	1,285,777		42.4%	2,697,522	(1,411,746)	
HURON VALLEY		33,984	29.70%	10,093		42.4%	14,409	(4,316)	
REHAB INSTITUTE		445,659	44.09%	196,491		42.4%	188,959	7,532	
SINAI/GRACE		8,228,802	34.00%	2,797,793		42.4%	3,489,012	(691,219)	
MEDICAID OUTPATIENT		$ 43,176,390		$ 15,231,396	$38.73		$ 18,306,789	**(3,075,393)**	
TOTAL CAPITATED MEDICAID SERVICES						DISTRIBUTION CAP FFS BASIS			
HARPER	3,450	$ 22,656,696		$ 8,286,756		5,370,404	$ 9,606,439	$ (1,319,683)	$ (4,236,035)
HUTZEL	1,940	9,806,100		3,378,986		2,189,822	4,157,786	(778,800)	(1,967,964)
KARMANOS	850	8,751,579		3,244,635		2,102,753	3,710,669	(466,035)	(1,607,917)
CHILDRENS	1,903	16,443,761		6,256,023		4,054,345	6,972,155	(716,132)	(2,917,810)
DETROIT RECEIVING	3,167	25,637,898		6,088,574		3,945,827	10,870,469	(4,781,894)	(6,924,642)
HURON VALLEY	12	83,308		24,602		15,944	35,322	(10,720)	(19,379)
REHAB INSTITUTE	609	1,849,425		665,421		431,240	784,156	(118,735)	(352,916)
SINAI/GRACE	3,302	21,611,240		7,496,063		4,857,979	9,163,166	(1,667,103)	(4,305,187)
TOTAL MEDICAID	15,233	$ 106,840,006		$ 35,441,060	$90.13	$22,968,312	$ 45,300,162	$ (9,859,102)	$ (22,331,850)
OMNICARE MEDICAID CAP GROSS				28,710,390	$73.01				
TOTAL OMNICARE CAP				28,710,390	$73.01				
OMNICARE MEDICAID CAP WITHHOLD			20.00%	(5,742,078)	-$14.60				
OMNICARE MEDICAID CAP NET				$22,968,312	$58.41		$ 45,300,162		**$ (22,331,850)**
CAP GREATER/(LESS) THAN MEDICAID FFS @ DEC YTD				**($12,472,748)**	($31.72)				

DETROIT MEDICAL CENTER
ANALYSIS OF CAPITATED OMNICARE BUSINESS
HOSPITAL CHARGES & ESTIMATED PAYMENTS
JANUARY - SEPTEMBER 2004

HOSP	SEP YTD 2004 DAYS	SEP YTD 2004 INPATIENT CHARGES	2004 FFS RATE	SEP YTD 2004 TOTAL FFS PAYMENT	YTD MEMBER MONTHS	COST RATIO	SEP YTD 2004 TOTAL COST	COST VS MEDICAID FFS	COST VS OMNI CAP
INPATIENT CAPITATED MEDICAID SERVICE					236,828				
				AVG	26,314				
HARPER/HUTZEL	3,258	$ 13,548,425	DRG	$ 6,579,542		41.3%	$ 5,595,500	$ 984,042	
CHILDRENS	1,141	4,622,261	DRG	1,662,901		41.3%	1,908,994	(246,092)	
DETROIT RECEIVING	1,628	11,325,109	DRG	2,605,660		41.3%	4,677,270	(2,071,610)	
HURON VALLEY	4	32,141	DRG	6,463		41.3%	13,274	(6,811)	
REHAB INSTITUTE	271	613,691	PER DIEM	208,670		41.3%	253,454	(44,784)	
SINAI/GRACE	2,394	10,007,604	DRG	2,605,660		41.3%	4,133,140	(1,527,480)	
TOTAL MEDICAID IN	**8,696**	**$ 40,149,230**		**$ 13,668,896**			**$ 16,581,632**	**$ (2,912,736)**	
OUTPATIENT CAPITATED MEDICAID SERVICE									
HARPER/HUTZEL		$ 13,276,643	37.42%	$ 4,968,120		41.3%	$ 5,483,254	$ (515,134)	
CHILDRENS		7,814,896	36.21%	2,829,774		41.3%	3,227,552	(397,778)	
DETROIT RECEIVING		3,916,770	20.48%	802,154		41.3%	1,617,626	(815,471)	
HURON VALLEY		7,313	19.14%	1,400		41.3%	3,020	(1,621)	
REHAB INSTITUTE		315,102	40.45%	127,459		41.3%	130,137	(2,678)	
SINAI/GRACE		6,112,645	32.53%	1,988,443		41.3%	2,524,522	(536,079)	
TOTAL MEDICAID OUTPATIENT		**$ 31,443,369**		**$ 10,717,350**			**$ 12,986,111**	**$ (2,268,761)**	
						DISTRIBUTION			
TOTAL CAPITATED MEDICAID SERVICES						CAP FFS BASIS			
HARPER/HUTZEL	3,258	$ 26,825,068		$ 11,547,662		$ 6,458,745	$ 11,078,753	$ 468,908	($4,620,008)
CHILDRENS	1,141	12,437,157		4,492,675		2,512,807	$ 5,136,546	(643,871)	(2,623,739)
DETROIT RECEIVING	1,628	15,241,879		3,407,815		1,906,031	$ 6,294,896	(2,887,081)	(4,388,864)
HURON VALLEY	4	39,453		7,863		4,398	$ 16,294	(8,432)	(11,897)
REHAB INSTITUTE	271	928,793		336,129		188,001	$ 383,592	(47,463)	(195,591)
SINAI/GRACE	2,394	16,120,249		4,594,104		2,569,537	$ 6,657,663	(2,063,559)	(4,088,126)
TOTAL MEDICAID	**8,696**	**$ 71,592,599**		**$ 24,386,247**	**$102.97**	**$ 13,639,519**	**$ 29,567,744**	**$ (5,181,497)**	**($15,928,224)**
OMNI MEDICAID CAP GROSS				17,049,399	**$71.99**				
OMNI MEDICAID CAP WITHHOLD				(3,409,880)	**($14.40)**				
OMNI MEDICAID CAP NET				13,639,519	**$57.59**		29,567,744		**$ (15,928,224)**
CAP LESS THAN MEDICAID FFS		SEPT YTD 2004		**(10,746,727)**	**($45.38)**				



STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL CIRCUIT
INGHAM COUNTY

COMMISSIONER OF INSURANCE
FOR THE STATE OF MICHIGAN,
Petitioner,

File No. 98-88265-CR

v

Hon. James R. Giddings

MICHIGAN HEALTH MAINTENANCE
ORGANIZATION PLANS, INC., a
Michigan health maintenance organization,
doing business as OmniCare Health Plan,
Respondent.
/

MARK J. ZAUSMER (P31721)
AMY M. SITNER (P46900)
Zausmer, Kaufman, August & Caldwell, P.C.
Attorneys for Petitioner
31700 Middlebelt Road, Suite 150
Farmington Hills, MI 48334
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/

ORDER REGARDING THE CLAIM PRIORITY OF THE DETROIT MEDICAL CENTER'S PROOF OF CLAIM DATED FEBRUARY 15, 2005 ALLEGING, *INTER ALIA*, BREACH OF CONTRACT AND MISREPRESENTATION

At as session of said Court, held in the Courtroom thereof, in the City of Lansing, County of Ingham, State of Michigan, this November 8, 2005.

PRESENT: HON. _____
CIRCUIT COURT JUDGE

This matter having come before the Court on the Court's May 12, 2005, Corrected and Amended Order Setting Briefing Schedule and Establishing Notice Procedure with Respect to the Issue of the Priority of Provider Claims, Briefs having been filed and the Court having heard oral

argument and being otherwise fully advised in the premises:

IT IS HEREBY ORDERED that, for the reasons stated on the record at the October 28, 2005 hearing, the issue of the priority of the Detroit Medical Center's Proof of Claim dated February 15, 2005, alleging *inter alia* breach of contract and misrepresentation, if the court process ultimately results in a ruling that the claim is otherwise valid, is taken under advisement by the Court for determination at a later date.

IT IS FURTHER ORDERED that because DMC contends its claim is Class 2, consistent with MCL 500.8142(1), no payments on Class 2 or lower claims will be made while the above-referenced Detroit Medical Center Proof of Claim remains unresolved, unless adequate funds are retained for payment of the amount alleged in that claim.

This is not a final order.

JAMES R. GIDDINGS

CIRCUIT COURT JUDGE

Approved for entry:

Mark J. Zausmer (P31721)
Amy M. Sitner (P46900)
Attorneys for the Liquidator

Charles N. Raimi (P29746)
Attorney for DMC

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Michigan HMO Plans, Inc.
Liquidation Balance Sheet based on Detroit Medical Center Settlement
(in 000's)

	@ $0		@ $750 Class 2		@ $750 Class 5	
Total Assets	**$ 15,759**		**$ 15,759**		**$ 15,759**	
Class 1: Administrative Payables						
Accrued Liquidation Expense	827		827		827	
OmnCare TPA Payables	369		369		369	
Total Class 1	**1,196**	**100%**	**1,196**	**100%**	**1,196**	**100%**
Class 2: Claims on Policies						
Detroit Medical Center	-		750		-	
Adjudicated Provider Claims	12,515		12,515		12,515	
Value Options, Inc.	100		100		100	
Medicare	58		58		58	
Capitation Withhold & Incentive Pool Bonus	73		73		73	
Total Class 2	**12,746**	**100%**	**13,496**	**100%**	**12,746**	**100%**
Class 3: Federal Government	**782**	**100%**	**782**	**100%**	**782**	**100%**
Class 4: Bodily Injury or PD Claims	**None**		**None**		**None**	
Class 5: General Creditors						
Detroit Medical Center	-		-		750	
Trade Vendors	12		12		12	
Total Class 5	**12**	**100%**	**12**	**100%**	**762**	**100%**
Class 6: State & Local Government						
Regulatory Assesment Fee	36		36		36	
QAAP Tax Liabiltiy	2,563		2,563		2,563	
Total Class 6	**2,599**	**39%**	**2,599**	**11%**	**2,599**	**11%**
Class 7: Late Filed Claims	**6,449**	**0%**	**6,449**	**0%**	**6,449**	**0%**
Class 8: Surplus or Contribution Notes						
Provider Surplus Notes	**70**	**0%**	**70**	**0%**	**70**	**0%**
Class 9: Shareholder Claims	**None**		**None**		**None**	
Total Creditor Claims/Liabilities	**$ 23,854**		**$ 24,604**		**$ 24,604**	